| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255126 | A. Building<br>B. Wing | 03/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wilkinson County Senior Care | 116 South Lafayette Street<br>Centreville, MS 39631 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>48669<br><br>Based on observation, staff and Resident Representative (RR) interview, record review, and facility policy review, the facility failed to ensure the comprehensive care plan was implemented for Activities of Daily Living (ADL) for one (1) of 16 sampled residents. (Resident #30)<br><br>Findings include:<br><br>Review of the facility's policy titled, Care Plan-Comprehensive, dated 10/2016 revealed, Policy Statement: . An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or resident representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain . 3. Each resident's comprehensive care plan is designed to . d. Reflect the resident's expressed wishes regarding care and treatment goals .<br><br>A record review of the comprehensive Care Plan with a date initiated of 12/10/2019, revealed FOCUS: The resident has an ADL Self-Care Performance Deficit .Interventions . The resident requires total assistance with personal hygiene .<br><br>During an interview with the RR for Resident #30, on 3/25/24 at 10:46 AM, she revealed the facility has failed to keep her brother's toenails cut.<br><br>During an observation on 3/25/24 11:02 AM, of Resident #30's toenails revealed the resident's toenails were thick, yellow, and extended post of the end of his toes.<br><br>During an interview on 3/27/24 at 10:24 AM, Licensed Practical Nurse (LPN) #5 confirmed Resident #30's toenails were long and past due time for cutting.<br><br>During an interview with Registered Nurse (RN) #1 on 3/28/24 at 12:32 PM, when discussing the Care Plan,<br><br>RN #1 revealed the care plan is designed to provide information to staff on how care for residents. She confirmed that ADL care includes nail care.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/28/24 at 1:57 PM, the Director of Nursing (DON), confirmed the purpose of the care plan is to ensure residents' needs are met. She pointed out that ADL care included cutting of the toenails. She stated that if the care plan is not followed, it could result in additional needs of the resident. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>48669<br><br>Based on observation, staff and Resident Representative (RR) interviews, record review, and facility policy review, the facility failed to ensure a dependent resident received Activities of Daily Living (ADL) care, as evidenced by long thick toenails for one (1) of 16 sampled residents. (Resident #30)<br><br>Findings include:<br><br>Review of the facility's policy titles, ADL Care Policy, dated 8/23 revealed, POLICY It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis, while attaining or maintaining the residence of highest, practicable, physical, mental, and social well-being . 2. The resident, to the extent possible, and /or the family/resident representative will be included in setting goals of care related to ADL's .<br><br>On 3/25/24 at 10:46 AM, during an interview with the RR for Resident #30, she revealed she has concerned about the resident's toenails. She said the facility has failed to keep them cut.<br><br>On 3/25/24 at 11:02 AM, in an observation and interview of Resident #30's toenails revealed his toenails were yellow, thick, and extended over the toes. When asked if he would like his toenails to be cut regularly, Resident #30 nodded yes.<br><br>On 3/26/24 at 3:36 PM, an observation of Resident #30, revealed his toenails are still uncut and the appearance remains unchanged from the observation on 3/25/24<br><br>On 3/27/24 at 10:24 AM, in an interview and observation, regarding the toenails of Resident #30, Licensed Practical Nurse (LPN) #5 indicated from what she knows, it is the role of the Registered Nurse (RN) to cut the toenails of the residents. During the observation, LPN #5 confirmed that the resident's toenails are long and past due time for cutting.<br><br>On 3/27/24 at 10:40 AM, in an interview with LPN #3 the Medical Records Nurse, she points out that both RNs and LPNs are responsible for cutting toenails, depending on the diagnoses of the resident. However, in the case of Resident #30, since he is not a diabetic, any nurse can cut his toenails. She stated that she usually notes on her spreadsheet if a resident refuses care when the Podiatrist comes. She points to the spreadsheet on her computer screen and indicated Resident # 30 has not refused nail care. She revealed the Podiatrist comes every three months but does not see every resident on each visit. She pointed out that the podiatrist last saw Resident #30 on 1/24/24 and she does not have any records of him ever refusing care. She added the podiatrist is scheduled to come Saturday (3-30-24), and Resident # 30 is on the list to be seen.<br><br>On 3/27/24 at 11:03 AM, in an interview and observation of Resident # 30 toenails with the Director of Nurses (DON), she stated she cannot disagree that his toenails need to be cut but she does admit that staff has told her he refused to get his toenails cut.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of a printed nurse's note provided by the DON, dated 3/27/24, and signed by LPN #6 indicated Resident #30 refused nail care today.<br><br>On 3/28/24 at 11:12 AM, in a second interview with the RR, she revealed she comes to see her brother every Tuesday and Saturday. She mentioned that on multiple of visits she had asked the staff to cut his toenails and they would respond by indicating it would be taken care of. However, each time she came, she noticed they were still not cut. She stated that when she had asked the staff if she could cut them. She stated she was told it is the facility's responsibility to cut his toenails, so she was not allowed to do so. The RR added that it had never been brought to her attention that her brother was refusing nail care.<br><br>On 3/28/24 at 12:32 PM, in an interview with RN#1, she revealed there have been times that the facility would send residents out to the podiatrist for toenail care when the need was identified. She added that this is done when the podiatrist scheduled in-house visit is still a few weeks away.<br><br>On 3/28/24 at 1:57 PM, in an interview with the DON, she described Resident #30's toenails as thick and 1/4 of an inch the past the end of his toe. She indicated it is the nurse's responsibility to cut residents toenails between podiatrist visits. She confirmed the facility does send residents out to the podiatrist if it is needed. She described this need as when staff is unable to cut the toenails.<br><br>A record review of the Admission Record for Resident #30 revealed the facility admitted the resident on 11/19/2019. His diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction and Thoracic, Thoracolumbar and Lumbosacral Interverbal Disc Disorder.<br><br>A record review of the Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 3/5/24, revealed that Resident #30 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated that the resident had severe cognitive impairment. Further review of the MDS revealed the resident id dependent for personal hygiene,<br><br>A record review of the Order Summary Report, with active orders as of 3/28/24 revealed a physician order dated 4/5/23 . May have Podiatry .Consult PRN (as needed). |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>47873<br><br>Based on interviews, record review, and facility policy review, the facility failed to inform a resident or Resident Representative (RR) of the risks and benefits of the use of bed rails prior to bed rail installation for one (1) of 16 sampled residents. (Resident #14)<br><br>Findings include:<br><br>Review of the facility policy titled, Physical Restraints, dated 2/20/2012, revealed, .Restraints shall only be used for the safety and well-being of the residents .1. Restraints will only be used with . the informed consent from the resident, physician and/or responsible party . 5. Practices that are not permitted include: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed<br><br>On 3/25/24 at 10:30 AM, an observation revealed 1/4 bedrails on the bed of Resident #14. The resident was not in bed and the bedrails were down.<br><br>On 03/27/24 at 10:30 AM, during an interview and record review of the medical record with Licensed Practical Nurse (LPN) #1 confirmed Resident #14 did not have an order for the use of bed rails in the physician's orders. Bed rails were not listed on the Kardex (nursing worksheet that includes a summary of resident information and daily care) nor was there a signed informed consent for the use of bed rails that included the risk and benefits of bed rail use.<br><br>On 3/27/24 at 11:00 AM, in an interview with the RR for Resident #14, she revealed she was a part of the admission of her mother into the facility. The RR stated she cannot recall all the documents she signed but does remember the discussion of informed consent for the use of safety devices, if needed. She added that she has no remembrance of signing any documents related to bed rails for her mother, but does know they are on her bed, as she has seen them on visits.<br><br>On 03/27/24 at 11:45 PM, in an interview with Registered Nurse (RN) #1/MDS Nurse confirmed the medical record for Resident #14 did not have an informed consent that indicated the benefits and risks of the use of bed rails.<br><br>On 03/27/24 at 12:00 PM, in an interview with the Director of Nurses (DON), she confirmed Resident #14 does not have the appropriate consent for the use of bed rails, nor was the bed rails included in the resident's Kardex.<br><br>Review of the Admission Record revealed the facility admitted Resident #14 on 08/10/23, with diagnoses that included Unspecified Dementia, Bradycardia, and Syncope and Collapse.<br><br>Record review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/14/24, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>41680<br><br>Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure that tray line food temperatures were checked and documented prior to serving each meal for 15 days of 24 days of recorded temperatures reviewed for the month of March 2024.<br><br>Findings include:<br><br>Review of the facility's policy titled, Monitoring Temperature of Cooked Foods, with a revision date of 10/17, revealed . POLICY: The temperature of TCS (Time/Temperature Control) cooked foods will be monitored to ensure that the foods are not in the danger zone (above 41degrees F {Fahrenheit} and below135 degrees F) for more than 6 hours PROCEDURE: 2 . b. When food is placed in the hot holding equipment. The temperature of the food should be 135 degrees F or higher .<br><br>On 03/25/24 at 9:40 AM, an initial tour of the kitchen with the Dietary Manager (DM) revealed several of the pages in the tray line temperature log binder, were incomplete or blank. The DM stated she expects staff to check tray line food temperatures and document the temperatures in the binder. She stated she recently did an inservice on checking temperatures and staff knows the requirements.<br><br>On 03/27/24 at 10:55 AM, in an interview with Cook #1 she stated she always checks tray line temperatures before serving food. She stated she may have forgotten to write them in the book. She confirmed they are supposed to be documented when they are done.<br><br>Review of the of the temperature log sheets revealed on 3/10/24 dinner temperatures logs were blank, 3/11/24 the entire page was blank, 3/12/24 lunch was blank, 3/13/24, 3/14/24 and 3/15/24 breakfast and lunch were blank, and 3/16/24- 3/24/24 all meals were blank.<br><br>On 3/28/24 at 3:00 PM, in an interview with the Administrator, she stated she had inserviced the DM on the importance of documenting the tray line temperatures. She revealed that for resident safety, she expects the temperatures to be checked and recorded. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>41680<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure the facility's designated Hospice Coordinator coordinated the care provided by the Hospice service and the facility for one (1) of two (2) Hospice residents reviewed. (Resident #27)<br><br>Findings include:<br><br>A review of facility's policy titled, Hospice Program, dated 7/13/17, revealed, It is the policy of the facility to contract hospice services for residents who wish to participate in such programs .Procedure: 8. As the facility designee, the Director of Nursing, is responsible for working with hospice representatives to coordinate care to the resident provided by the facility staff and hospice staff. The Director of Nursing is responsible for the following: a. Collaborating with hospice and coordinating the facility staff participation in the hospice care planning process. b. Communicating with hospice staff participating in the care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family .<br><br>On 03/25/24 at 1:26 PM, in an observation of Resident # 27, was observed in his room with his eyes closed. The resident was nonverbal and did not respond to his name.<br><br>On 03/27/24 02:15 AM, in an interview with Social Service (SS), she revealed when a resident is admitted to Hospice, she coordinates the initial Hospice communication with the family. She stated she contacts the Hospice service that the family chooses and sets up the initial meeting. However, she stated she does not coordinate with Hospice after the resident is admitted to their services.<br><br>On 03/27/24 at 2:25 PM, in an interview and observation with Licensed Practical Nurse (LPN) #3/Medical Records, she stated she keeps track of the Hospice records only. She stated the current Hospice records should be in the Hospice chart for the staff to use. LPN #3 sorted through stacks of Hospice records and pulled out notes dated 2/20/24. She continued to look through the stacks and found 3/1/24 through 3/18/24 Hospice notes.<br><br>On 03/27/24 at 2:32 PM, in an interview with LPN #2 stated she does not use the Hospice chart to provide care to the hospice resident (Resident #27). She stated she uses the records in Point Click Care (The facility's electronic computerized medical records). She revealed the Hospice Certified Nurse Assistant (CNA) comes Monday, Wednesday, and Friday, however, she stated she is not sure when the Hospice nurse comes.<br><br>On 3/27/24 at 2:39 PM, in an interview with LPN #1 stated the Hospice nurse talks to the unit manager and unit manager informs the staff. She stated any changes are passed on shift to shift. She stated she uses the Hospice chart when she has a Hospice resident if they put the records in the chart.<br><br>On 3/27/24 at 2:54 PM, in an interview with the Director of Nursing (DON) revealed that Resident # 27's Hospice records from 1/3/24 through 2/15/24, were in the resident's facility chart. She stated the nurse cannot use Hospice information if it is not in the chart, so one of the prior nurses put the Hospice records in the facility chart to facilitate facility use.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/28/24 at 11:58 AM, in a telephone interview, the Hospice Registered Nurse (RN) stated she comes to see the resident once a week. She does not attend care plan meetings and has never been asked to attend any meeting regarding the resident. She stated she is not aware of how the facility does their Hospice. She commented when she comes to the facility and does the assessment on the resident, she talks with the nurse at the nurse's station or any nurse she sees in the hallway, as she has never been told who to inform of her assessment. The Hospice RN revealed that she would like to talk with the Unit Manager, but sometimes she cannot find her. The RN stated she or the Hospice CNA brings the charting to the facility and gives them to whoever is at the nurse's station. She stated the facility has never informed her to give them to medical records or any specific staff member.<br><br>On 03/28/24 12:43 PM in an interview with RN #1, the MDS (Minimum Data Set)/Care Plan Nurse stated the family is advised when the care plan meeting will be. She stated Social Services contacts the family and invites them to come to the care plan meetings. She stated they are held on every Tuesday at 2 PM. She stated they discuss 5-6 residents a week. She stated Resident # 27's Hospice nurse has not attended any of the care plan meetings since she has been here. She stated she has only been at the facility for 6 weeks. She stated they recently conducted Resident # 27's Care Plan Meeting, however, the family nor Hospice were in attendance. She stated Hospice nurses should attend meetings; they are part of the plan of care.<br><br>On 03/28/24 at 12:50 PM, in an interview the DON stated Hospice communicates with whoever they can find at the nurse's station. She stated Hospice staff are supposed to give the records to the medical records and medical records are responsible for putting them in the Hospice chart. She stated she is aware that the DON should coordinate Hospice, however, she delegates that responsibility to Social Services. The DON revealed she is not sure if Hospice has attended the care plan meetings, but they should because they are part of the plan of care. She stated Hospice records should be in the Hospice chart at the nurse's station, so they are accessible to staff for use in resident care.<br><br>On 03/28/24 at 3:09 PM, in an interview the Administrator stated she expects staff to follow up with Hospice. She stated she expects staff to coordinate with the Hospice so the residents can get the best of care from both Hospice and the facility.<br><br>Review of the Admission Record, Resident #27 reveled the facility admitted the resident on 12/3/18, with diagnoses that included Cerebral palsy, Scoliosis, Essential Hypertension, and Dysphagia.<br><br>Review of Order Summary Report, dated 3/29/24 for Resident #27, revealed a physician order, dated 7/29/22, to admit the resident to a local hospice service, due to the diagnosis of Nutritional Deficit.<br><br>Review of the Minimum Data Set (MDS), for Resident #27, with Assessment Reference Date (ARD) 3/19/24, revealed the resident has severely impaired cognitive skills for daily decision making. Further review of the MDS revealed the resident was coded for Hospice. |