

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Shady Lawn Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 60 Shady Lawn Place Vicksburg, MS 39180	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to transmit accurate assessments for two (2) of 2 residents reviewed for Minimum Data Set (MDS) assessments. Resident #5 and Resident #10.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medicare Management with a revision date of 10-2023 revealed, .b . Coding of Assessment: i. All disciplines shall follow the guidelines in Chapter 3 of the current Resident Assessment Instrument (RAI) Manual for coding each assessment.</p> <p>Review of the facility policy titled, Chapter 3: Overview to the item-by-item guide to the MDS 3.0 dated October 2023 revealed, This chapter provides item-by-item coding instructions for all required sections and items in the MDS Version 3.0 item sets. The goal of this chapter is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes .</p> <p>Resident #5</p> <p>A record review of Admission 5-day MDS with an Assessment Reference Date (ARD) of 4/3/2024 revealed, Section H-Bladder and Bowel that Resident #5 was coded under Urinary and Bowel Continence as always incontinent.</p> <p>A record review of the Documentation Survey Report dated March 2024 and April 2024 for the seven (7)-day look back period of March 27-April 2 for Resident #5 revealed the resident had 13 bladder incontinent episodes, nine (9) continent bladder episodes and had 10 bowel incontinent episodes and eight (8) continent bowel episodes.</p> <p>During an interview on 5/01/24 at 11:40 AM, Resident #5 revealed I usually use my bedside commode or ask for a bedpan. Still, I occasionally have an accident which is why I wear briefs.</p> <p>During an interview and record review on 5/01/24 at 2:40 PM, the MDS Nurse confirmed during the seven-day look-back period documentation from March 27 through April 2, Resident #5 was continent of the bladder 9 times and incontinent 13 times. She confirmed the resident was incontinent of bowel 10 times and had 8 continent bowel episodes. She confirmed Resident #5 should have been coded as frequently incontinent of bowel and bladder instead of coded as always incontinent.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 5/01/24 at 3:05 PM, the Director of Nurses (DON) confirmed Resident #5's Bowel and Bladder (Section H) MDS assessment was coded inaccurately and failed to represent an accurate assessment of the resident.</p> <p>A record review of Resident #5's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Fracture of the right Patella, End Stage Renal Disease, and Diastolic (Congestive) Heart Failure.</p> <p>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/24 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.</p> <p>Resident #10</p> <p>Record review of the Order Summary Report with active orders as of 4/17/24 for Resident #10 revealed orders dated 11/21/2023, Wanderguard: Check placement and function every shift and Wanderguard: Monitor residents whereabouts q (every) 2 (two) hrs (hours).</p> <p>An observation on 4/30/2024 at 10:40 AM, revealed Resident #10 sitting in a chair in the activity room. A wander alert bracelet was observed on his right arm.</p> <p>Record review of Resident #10's Quarterly MDS with an ARD of 4/17/2024 revealed under section P, wander/elopement alarm was indicated not used during the assessment look back period.</p> <p>An interview with the MDS Nurse on 5/1/2024 at 12:00 PM, confirmed an error was made on Resident #10's Quarterly MDS. She revealed that the wanderguard should have been marked as used daily. She revealed the purpose of the MDS was to paint a complete picture of the resident.</p> <p>An interview with the Director of Nursing (DON) on 5/1/2024 at 3:12 PM, confirmed an error was made on Resident #10's MDS and the wanderguard was not captured. She revealed the MDS did not represent an accurate assessment of the resident.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #10 on 8/21/2023 with medical diagnoses that included Schizophrenia and Mild intellectual disabilities.</p> <p>47874</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>39807</p> <p>Based on observations, resident and staff interview, record review, and facility policy review the facility failed to develop a smoking care plan for Resident #36 and failed to develop a care plan for nail care for Resident #63 for two (2) of 19 care plans reviewed. Resident #36 and Resident #63.</p> <p>Findings include.</p> <p>A review of the facility policy with a revision date of 03/2019, titled Comprehensive Care Plan, revealed: Standard: It is the policy of this facility to develop and implement a comprehensive person - centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment .</p> <p>Resident #36</p> <p>Record review of Resident #36's care plan with a date initiated:5/4/22 and a resolved date: 9/29/22 revealed Focus RESOLVED: The resident is at risk for injury r/t (related to) smoking Cigarettes and keeps a Cigar in his mouth . The desired outcome and all interventions were marked RESOLVED.</p> <p>Record review of Resident #36's .Smoking and Safety evaluation dated 3/20/24 revealed .2. Which of the following products does the Resident use? The response was checked 1. Tobacco</p> <p>An interview on 05/01/24 at 3:50 PM, with the Minimum Data Set (MDS) Nurse confirmed that Resident #36 does smoke tobacco occasionally and that he does not have a current care plan for smoking but that he should. The MDS nurse confirmed that the resident had a care plan for smoking that was resolved 9/29/22. The MDS nurse revealed that the purpose of having a care plan is to guide the residents care safely and that without a care plan a resident can receive care the wrong way.</p> <p>An observation and interview, on 05/01/24 at 4:00 PM with Licensed Practical Nurse (LPN) #1 confirmed Resident #36 does smoke tobacco occasionally, but not every day. LPN #1 stated We offer him to go for each smoke break, sometimes he does and sometimes he doesn't go. LPN #1 revealed that the resident has one full unopened pack of cigarettes and one pack of cigarettes that is open and has cigarettes missing from the pack. Both packs of cigarettes had the residents name written on them and they were located inside of the facility smoke box.</p> <p>An interview, on 05/01/24 at 4:05 PM with Resident #36 confirmed that he does smoke tobacco occasionally.</p> <p>An interview on 05/02/24 at 8:00 AM, with the Administrator confirmed that the purpose of the care plan is to guide the residents care safely and without the care plan the resident can receive the wrong care.</p> <p>Resident #63</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the care plans revealed (Proper name of Resident #63) has an ADL (Activities of Daily Living) deficit .Desired Outcome .The resident will maintain or improve current ability in .Personal Hygiene . There were no interventions/task developed for nail care for Resident #63 included in the care plan.</p> <p>During an observation on 4/30/2024 at 2:42 PM, Resident #63 was sitting in a wheelchair in the activity room. Excessively long, thick, discolored fingernails observed on both hands measuring approximately one-half (1/2) inch in length.</p> <p>An observation and interview on 5/1/2024 at 10:35 AM, with Licensed Practical Nurse (LPN) #2, confirmed Resident #63 had long nails that needed to be cut.</p> <p>An interview with the Minimum Data Set Nurse (MDS) on 5/2/2024 at 10:01 AM, confirmed the resident did not have a care plan developed for nail care. She revealed they did not have the nail care task developed for Resident #63; therefore, a care plan had not been developed. She explained the purpose of the care plan was to guide the staff with the resident care to be given.</p> <p>47874</p>		