

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER MS Care Center of Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 East Union Street Greenville, MS 38703	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>Based on resident and staff interviews, record reviews, and facility policy reviews, the facility failed to honor a resident's rights to make her own healthcare decisions for end-of-life care for one (1) of 24 residents reviewed for advanced directives. Resident #3</p> <p>Findings include:</p> <p>Record review of the facility policy titled, Advance Directives with a revision date of 9/2022 revealed The resident has 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. Facility will inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment at the resident's option and to formulate an Advanced Directive.</p> <p>Record review of the Physician Statement of Status of Mental Capacity of Resident dated 1/23/24 revealed that the physician checked Competent, revealing that the resident was able to make her own decisions.</p> <p>Record review of the DNR (Do Not Resuscitate)/Full Code Request and Consent form dated 1/23/24 revealed Resident #3 had not signed her consent form and that it was signed by a family member.</p> <p>In an interview on 2/04/25 at 3:00 PM, Resident #3 revealed she could make her own decisions, and when she was admitted to the facility, no one talked with her about her end-of-life wishes. She revealed her niece had already signed all the paperwork and she did not sign her own Advance Directive. She stated, I had my legs cut off, not my brain, and revealed no one had gone over the paperwork with her.</p> <p>An interview on 2/04/25 at 3:31 PM, with the Admission Nurse revealed that she met with the family and had the paperwork signed prior to the resident's admission. She revealed that their physician also sees the resident prior to admission and deems the resident competent or non-competent in determining whether they can sign their own paperwork. She revealed Resident #3 was deemed competent; however, the niece signed the Advance Directive instead of the resident. She revealed that Resident #3 was able to make her own decisions and should have been given the opportunity to make her own decisions regarding her Advance Directive.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 2/05/25 at 9:40 AM, the Administrator revealed that if a resident is able and competent to sign their own advance directive, the facility should go over the paperwork with the resident and allow them to sign.</p> <p>Record review of the Admission Record revealed Resident #3 was admitted to the facility on [DATE] with medical diagnoses that included Hypertensive Heart Disease with Heart Failure, Cerebral Infarction, Acquired absence of right leg below the knee, and Acquired absence of left leg above the knee.</p> <p>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/6/25, revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #3 was cognitively intact.</p>

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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>Ensure each resident receives an accurate assessment.</p> <p>47874</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to accurately complete Section A of the Minimum Data Set (MDS) for a resident with a serious mental illness (SMI) for one (1) of 21 MDS reviewed. Resident #23</p> <p>Findings Include:</p> <p>Review of the facility policy titled Accuracy of Assessments unrevised revealed, The facility must ensure the assessment represents accurately the resident's status during the observation/look back period. The assessment must be reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.</p> <p>Record review of the Preadmission Screening and Resident Review (PASRR) Summary of Findings Report dated 11/02/16 revealed under, Mental Health: The individual meets criteria for having a diagnosis of mental illness as defined by PASRR. Also revealed under, Axis I primary a diagnosis of Schizophrenia, paranoid type and under, Axis I secondary a diagnosis of Psychotic disorder.</p> <p>Record review of the Annual MDS with an Assessment Reference Date (ARD) of 4/18/24, revealed under, section A1500, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition? No was marked.</p> <p>An interview with the MDS Nurse on 2/04/25 at 3:10 PM confirmed, Resident #23 had a SMI and revealed the MDS was not coded correctly. She explained that she kept a list of the residents that had a Level II but must have overlooked it. The MDS Nurse revealed the purpose of having an accurate assessment was for the staff to provide the best possible care for the residents.</p> <p>An interview with the Administrator on 2/5/25 at 11:36 AM, revealed her expectations were for the MDS to be checked and submitted accurately, so the residents get the best quality of care for mental health.</p> <p>Record review of the Admission Record revealed the facility admitted Resident #23 on 10/12/16 with medical diagnoses that included Paranoid Schizophrenia, Unspecified Psychosis and Hallucinations.</p>