Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255264	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Comm Living Center	200 Long Street Booneville, MS 38829

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on staff interview, record review, and facility policy review, the facility failed to ensure accuracy of a code status based on the Power of Attorney for one (1) of 14 residents sampled. Resident #19 Findings include: Record review of facility policy titled, Advanced Directives reviewed ,d+[DATE], revealed, Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy .If the Resident has an Advance Directive: 1. If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DON) or designee notifies the attending physician of advance directive (or changes in advance directives) so that appropriate orders can be documented in the residents medical record and plan of care . Record review of Resident #19's Durable Power of Attorney for Health Care signed and dated by the resident on [DATE], revealed, Special Instructions: Do not resuscitate after one (1) hour of trying. No life support machine(s) in any town city, or state. Record review of electronic physician's order dated [DATE], revealed an order for DNR (Do Not Resuscitate). Record review of Order Details dated ,d+[DATE] revealed a physician's telephone order for a DNR, which was signed by the physician. Record review of Code Status form for Resident #19 signed by a family member and not the Resident's Representative on admission [DATE], revealed Do Not Attempt Resuscitation (DNR). (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:15 AM, the Administrator revealed the special instructions on Resident #19's Power of Attorney document for Do not resuscitate after one (1) hour of trying. No life support machine(s) in any town city, or state would indicate the Cardio-Pulmonary Resuscitation (CPR) should be initiated. She confirmed the physician's orders and code status form did not reflect the wishes conveyed in Resident #19's Durable Power of Attorney for Health Care document concerning his end-of-life care. She acknowledged this could lead to a resident not receiving the end-of-life care desired. She confirmed that record accuracy of end-of-life care was necessary to ensure the information concerning end of life care was reflective of the resident's wishes and the facility failed to accurately indicate Resident #19's choice for end-of-life care. Record review of Resident #19's Admission Record, revealed the facility admitted the resident on [DATE]. Diagnoses included Dysphagia following cerebral infarction and Chronic kidney disease. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident was moderately impaired cognitively.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, resident and staff interview, and facility policy review, the facility failed to provide a safe environment as evidenced by an overbed table with exposed jagged edges for one (1) of 44 resident's observed. Resident #37 Findings Included: Record review of the facility policy titled, Maintenance Service with revision date of December 2009, revealed, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . On 08/21/24 at 9:10 AM, an observation and interview revealed Resident #37 lying in bed with her over bed table positioned beside her on the right side of the bed. The plastic protective border was missing from all four sides of the over bed table and there were rough, jagged areas exposed. Resident #37 revealed that the rough edges on her over bed table could scratch her and if she rubbed up against the edges, she stated, It might bruise me. Resident #37 also revealed that her skin was thin and would easily tear. On 08/21/24 at 2:00 PM, an interview with Director of Nursing (DON) confirmed that Resident #37's over bed table had rough outer edges exposed and that the protective border was missing from all four sides. She revealed that the rough edges on the over bed table could cause skin tears or bruising. She revealed that this should have already been noticed and replaced. Record review of Resident #37's Admission Record revealed that she admitted on [DATE] and had diagnoses that included Unspecified Dementia, Anxiety, and Muscle Weakness. Record review of Resident #37's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/09/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated that she had moderate cognitive deficits.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff interviews, record review, and facility policy review, the facility failed to develop a person-centered care plan for residents with a diagnosis of Post-Traumatic Stress Disorder (PTSD) for two (2) of the 14 resident care plans reviewed. Resident #11 and Resident #37. Findings included: Review of the facility policy titled, Care Plans, Comprehensive Person-Centered undated revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. trauma-informed. Resident #11 Record review of Resident #11's care plans revealed the resident did not have a care plan regarding PTSD. During an interview on 8/20/24 at 1:16 PM, Resident #11 revealed she does have PTSD because she had a traumatic event happen to her as a child. An interview on 8/21/24 at 3:01 PM, Registered Nurse (RN)/ Minimum Data Set (MDS) Coordinator, confirmed Resident #11 does have a diagnosis of PTSD. However, she does not have a comprehensive care plan addressing this diagnosis. She revealed it was not developed because it was missed in error. She revealed that the care plan is developed so the staff knows how to care for each resident and Resident #11 should already have a care plan already in place for her PTSD. During an interview on 8/22/24 at 11:25 AM, the Director of Nurses (DON) confirmed Resident #11 has a diagnosis of PTSD. However, a trauma-informed care plan was not developed and was missed. She revealed it is very important that anyone with a PTSD diagnosis has a care plan addressing it. Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Peripheral Vascular Disease, and a PTSD diagnosis which was added with an onset date of 10/27/2023. Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date of 07/10/24, revealed in Section I that the resident had a diagnosis of PTSD and in Section C a Brief Interview Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #37 Record review of Resident #37's Care Plans revealed there was not a care plan in place to address PTSD that included triggers or interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 11:05 AM, an observation and interview with Resident #37 revealed she was sitting up in her wheelchair in her room. Resident #37 revealed that she had a three month old baby to die many years ago and also had an adult son who had passed away in his sleep about [AGE] years ago and this still bothered her. Resident #37 revealed that she often had nightmares, cried out in her sleep and had done this for a long time and didn't know what caused it. She also revealed that she worried about all of her kids and grandkids because she had lost her own children. On 08/21/24 at 3:05 PM, an interview with RN/MDS Coordinator confirmed the resident had a diagnosis of PTSD and did not have a comprehensive care plan addressing this diagnosis. She revealed that the care plan was developed so the staff knew how to take care of the individualized needs of the resident. The RN/MDS Coordinator confirmed that Resident #37's care plan for her PTSD had not been developed and that it should have been. On 08/22/24 at 11:45 AM, an interview with the DON revealed that the RN/MDS Coordinator was responsible for care planning the needs of each resident and that Resident #37's Trauma Informed Care Assessment should have been completed to help identify any possible triggers and these triggers should be included in her care plan. Record review of Resident #37's Psych Eval (Evaluation)dated June 20, 2024, revealed Recommendations: Add .Post traumatic stress disorder, chronic to diagnoses. Record review Resident #37's Admission Record revealed that she was admitted on [DATE] with diagnoses that included Unspecified Dementia with other behavioral disturbance, Anxiety Disorder and Hallucinations. The diagnosis of Post-Traumatic Stress Disorder, Chronic was added on 06/24/24. Record review of Resident #37's MDS with ARD of 05/09/24 under Section C revealed a BIMS score of 10 which indicated that she had moderate cognitive deficits. 45598

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on resident and staff interviews, record review, and facility policy review the facility failed to complete a Trauma Informed Care Assessment for a resident with Post Traumatic Stress Disorder (PTSD) diagnosis for one (1) of two (2) residents reviewed for PTSD. Resident #37. Findings Included: Record review of the undated facility policy titled Trauma Informed Care undated, revealed It is the policy of this facility to provide culturally competent, trauma-informed care to residents who are trauma survivors in accordance with professional standard of practice. On [DATE] at 11:05 AM, an observation and interview with Resident #37 revealed her sitting up in her wheelchair in her room. Resident #37 revealed that she had a three-month- old baby who died many years ago and also had an adult son who was found dead in his bed about [AGE] years ago and this caused her to worry a lot about her kids and grandkids. Resident #37 revealed that she often had nightmares and cried out in her sleep at night but didn't know what caused it. On [DATE] PM at 3:10 PM, an interview with Social Services revealed that she was responsible for completing the Trauma Informed Care Assessment on admission and any time there was a change in condition or a new diagnosis of PTSD. She revealed that she was not aware of Resident #37's PTSD diagnosis and confirmed that with this new diagnosis, she should have completed a Trauma Informed Care Assessment. Social Services revealed that they had a Care Plan Meeting with Resident #37 and her family and they reported that she yelled out at night during her sleep, that nothing seemed to trigger it, and that she had been doing it for a long time. She revealed that the family also denied any past traumatic events other than the death of two children that happened many years ago. Social Services revealed that Resident #37 was diagnosed with PTSD on [DATE] and it should have triggered them to do another Trauma Informed Care Assessment but they had missed it somehow. On [DATE] at 11:45 AM, an interview with Director of Nursing (DON) revealed that Resident #37 admitted to the facility on [DATE] for therapy services and was told by her family on [DATE] that she had to remain long-term in the facility and could not return to her home. The DON revealed that Resident #37 was upset and very tearful about having to stay long term. The DON revealed that they had not reported any other traumatic events in Resident #37's past other than her losing two of her children. The DON confirmed that they had discussed with the family about her crying out in her sleep and her family brushed it off and said that she cried out in her sleep all the time at home. She revealed that a psychiatric Nurse Practitioner evaluated Resident #37 and the new diagnosis of PTSD was added on [DATE]. The DON revealed that a Trauma Informed Care Assessment should have been completed with this new diagnosis and she didn't know why it wasn't done. Record review of Resident #37's Psych Eval (Evaluation)dated [DATE], revealed Recommendations: Add . Post traumatic stress disorder, chronic to diagnoses. Record review Resident #37's Admission Record revealed an admitted [DATE] with diagnoses that included Unspecified Dementia with other behavioral disturbance, Anxiety Disorder and Hallucinations. The diagnosis of Post-Traumatic Stress Disorder, Chronic was added on [DATE]. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #37's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 10 which indicated that she had moderate cognitive deficits.