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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pass Christian Health and Rehabiliation Center	538 Menge Avenue Pass Christian, MS 39571

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 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** 37415 Based on observation, interviews, record review and facility policy review the facility failed to develop a comprehensive care plan within 21 days of admission (Resident #22) and failed to implement a care plan intervention (Resident #32) for two (2) of 15 sampled residents. Findings include: Review of the facility's policy, Plans of Care, revised on 9/25/17, revealed, Policy: An individualized person-centered plan of care will be established .Procedure .Develop a comprehensive plan of care .within seven (7) days after completion of the comprehensive assessment (MDS) .The Individualized Person Centered plan of care may include .Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Individualized interventions that .promote achievement of the resident's goals . Resident #22 A review of Resident #22's medical record revealed there was no comprehensive care plan. A record review of the Admission Record revealed the facility admitted Resident #22 on 3/27/24. A record review of the Minimum Data Set (MDS) revealed Resident #22 had an Admission assessment with an Assessment Reference Date (ARD) of 4/03/24 completed. Resident #32 A record review of the Comprehensive Care Plan for Resident #32 revealed Focus (Proper Name) is at risk for decline in ADL (Activities of Daily Living) status .Intervention/Tasks .date initiated 3/30/24 . Mechanical lift x 2 person assist for transfers . A record review of the Order Summary Report, with active orders as of 4/23/24, revealed Resident #32 had a Physician's Order, dated 3/30/24, for Mechanical lift x (times) 2 person assist for transfers. Further review revealed she had diagnoses including Age-related Osteoporosis and Osteoarthritis. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/24 at 10:58 AM, during an observation, Certified Nursing Aide (CNA) #1 and CNA #2 were manually transferring Resident #32 from her bed to her wheelchair. The CNAs placed Resident #32 into her wheelchair on top of a lift pad that was positioned in the wheelchair. The CNAs did not use a mechanical lift during the transfer. On 4/21/24 at 11:01 AM, during an interview, CNA #1 confirmed they did not use a mechanical lift when transferring Resident #2. She explained the Kardex (CNA care guide) indicated the type of transfer that was required for the residents, and she verified that she did not look at the Kardex to determine how Resident #32 should have been transferred. On 4/24/24 at 9:00 AM, during an interview, the Director of Nursing (DON) confirmed the CNAs should have transferred Resident #32 with a mechanical lift and she stated expected the staff to transfer residents according to their physician orders and care plan. On 04/24/24, at 03:45 PM, in an interview with Registered Nurse (RN) #1, she explained she was responsible for initiating care plans. She acknowledged Resident #22 did not have a comprehensive care plan and it should have been developed within 21 days of his admission to the facility on [DATE] or within seven (7) days of the Admission MDS with an ARD of 4/3/24. RN #1 reported the purpose of the care plan was for staff to be aware of how to take care of the residents. RN #1 confirmed the staff failed to follow the care plan by not using the mechanical lift when transferring Resident #32. A record Review of the Admission Record revealed the facility admitted Resident #32 on 5/10/22. 43283 48181

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283 Based on observation, interviews, record review and facility policy review the facility failed to identify and treat two (2) new pressure ulcers (PUs) before they had deteriorated to Stage 3 pressure ulcers for one (1) of (2) residents reviewed for PU's. Resident #36. Findings include: A review of the facility's policy Skin and Wound, with a revision date of 01/24/22 revealed, Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention, and healing of pressure injuries . Process .Skin Impairment Identification: 1. Document presence of skin impairment (s)/new skin impairment(s) when observed and weekly until resolved. 2. Nurse to report changes in skin integrity to the physician/physician extender, resident/resident representative, and document in the medical record. 3. Develop resident centered intervention and document on the plan of care and the Aide Kardex . A review of the facility's policy Skin Evaluation, with a revision date of 04/01/17 revealed, Policy: A Licensed Nurse will complete a total body evaluation on each resident weekly .paying particular attention to any . pressure injury .reddened areas, and skin problems. Procedure .3. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas complete the 'Pressure Injury Record' . On 4/21/24 at 9:10 AM, during an interview and observation, Resident #36 was lying in bed, and he explained he was at the facility for rehabilitation and wound care. He said he had a wound to his sacrum when he was admitted to the facility on [DATE], but he was unsure if he had acquired any new wounds since he had been there. On 4/21/24 At 11:50 AM, during an interview and observation of wound care by Registered Nurse (RN) #2, Resident #36 had a PU noted to the sacrum. He also had an open area to the right lower buttock which had slough (nonviable tissue) noted to the wound bed, and another open area to the scrotum that also contained slough to the wound bed. RN #2 explained there were no physician orders for a treatment to the open areas to Resident #36's buttocks and scrotum. At 12:00 PM on 04/21/24, during an interview and observation with the Director of Nursing (DON), she confirmed Resident #36 had open areas to the right buttock and scrotum that contained a small amount of slough in the wound bed. She also confirmed these areas were not present when the resident was admitted to the facility on [DATE] and there was no documentation or physician's orders for a treatment. She stated that she expected the staff to monitor for any changes in a resident's skin and to notify someone if there were no treatments in place. She said the nurses and the Certified Nursing Assistants (CNAs) should have observed a change in the resident's skin. A record review of Physician's Orders revealed Resident #36 had an order dated 4/9/24 to Clean .Stage III wound to sacrococcygeal area . There were no other Physician Orders regarding treatments for any other wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A record review of the Weekly Skin Integrity Review forms, dated 04/02/24, 4/8/24, and 4/14/24 revealed Resident #36 had one wound to the sacrococcygeal/coccygeal area. There were no other skin impairments indicated on the weekly reviews. A record view of the facility's Weekly Wound Reports: Pressure Injury report dated the week of 04/05/24 and 4/12/24 revealed Resident #36 had one (1) wound to sacrococcygeal area. There were no other wounds listed for Resident #36. A review of the report dated week the of 04/19/24 revealed Resident #36 had wounds to the sacrococcygeal area, scrotum, and right buttock. A record review of the Wound-Weekly Observation Tool form for Resident #36 revealed the facility contacted the Medical Doctor (MD) on 4/21/24 due to Observed Stage III Wound to Scrotum While Performing Wound Care. The form indicated the date acquired was 4/21/24 and the Type was Pressure. The Visible Tissue' included granulation (new tissue) and slough, and the wound measurements were a length of 20 (mm) millimeters and width of 30 mm. A record review of the Wound-Weekly Observation Tool form for Resident #36 revealed the facility contacted the Medical Doctor (MD) on 4/21/24 due to Stage III wound to right buttock found while performing wound care. The form indicated the date acquired was 4/21/24 and the Type was Pressure. The Visible Tissue' included epithelial (healing tissue) and slough, and the wound measurements were a length of 25 (mm) millimeters and width of 20 mm. On 04/21/24 at 3:30 PM, during an interview with Resident #36, he explained he was not aware until today that he had new wounds. He said the staff had been completing wound care, but no one had mentioned that he had any redness or new open areas. He commented that he came to the facility to get his wound better and not to get new wounds. At 3:40 PM on 04/21/24, during an interview with CNA#3, she explained she had provided care for Resident #36 on one, or two evening shifts and he had a wound when he was admitted to the facility. CNA #3 explained that Resident #36 had loose bowel movements (BMs)which caused increased redness and new open areas to his bottom. She thought the nurses were aware of the new wounds because they had been there a while and they were applying cream to those areas. At 10:30 AM on 04/22/24, during a phone interview with Resident #36's family, she explained Resident #36 had a planned discharge from the facility late yesterday (4/21/24). She was aware he had a wound to the sacral area, but no one had told her that he had acquired new wounds while at the facility. She confirmed that she had observed the new wounds and had contacted the facility, and they advised a home health nurse would provide wound care for the resident. At 11:25 AM on 04/22/24, during an interview with RN #3, she explained she completed the admission assessment for Resident #36. She was unable to recall if there was any redness or excoriated areas, but she did recall that he had one wound to the sacral area. At 11:30 AM on 04/23/24, during an interview with RN #2, she explained the wound care nurse was no longer working at the facility and she had completed the Weekly Wound Reports. RN #2 said that she was now responsible for completing the Weekly Wound Reports starting this week. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/24/24 at 2:00 PM, during an interview with the DON, she explained the Weekly Skin Integrity Reviews and the Weekly Wound Reports completed for Resident #36 during his stay at the facility had no documentation that indicated he had redness or excoriations. The DON reported that she expected her nursing staff to ensure treatment orders were in place for wounds. At 02:45 PM on 04/24/24, during an interview with Licensed Practical Nurse (LPN) #2, she stated that when she completed wound care on Resident #36, he had a treatment to the coccyx/sacrum area and the surrounding skin was excoriated. She stated that she put barrier cream on the surrounding excoriations and commented that there were no open areas. LPN #2 confirmed that she completed the Weekly Skin Integrity Review (weekly skin audit) on 4/14/24 and she did not document Resident #36 had excoriations to the surrounding skin on the sacral area. She was unsure why she failed to document the excoriations. A record review of the Admission/Readmission Data Collection form, dated 04/01/24, indicated Resident #36 had a skin impairment on the sacrum upon admission to the facility. There was no description of the impairment listed on the form. A record review of the Braden Scale for Predicting Pressure Sore Risk, dated 04/02/24, revealed Resident #36 scored 15 which indicated he was at risk of developing a pressure sore. A record review of the Admission Record revealed the facility admitted Resident #36 on 4/1/24 with diagnoses that included Urinary Tract Infection. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/24 revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Section M revealed Resident #36 was at risk for developing pressure ulcers/injuries and had one (1) Stage 3 pressure ulcer.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37415 Based on observation, interviews, record review and facility policy review the facility failed to prevent the potential for an accident as evidenced by, facility staff transferred a resident without using the physician ordered mechanical lift for one (1) of four (4) transfer observations. Resident # 32 Findings include: Review of the facility's policy, Lifting and Moving Residents, dated 11/30/14, revealed, Policy: All residents will be assessed before attempting a transfer or move .Procedure . g. Lifting Aids: Are Hoyer (a type of mechanical lift) Lifts .required for transfer . A record review of the Order Summary Report with active orders as of 4/23/24, revealed Resident #32 had a Physician's Order, dated 3/30/24, for Mechanical lift x (times) 2 person assist for transfers. Further review revealed she had diagnoses including Age-related Osteoporosis and Osteoarthritis. During an observation on 4/21/24 at 10:58 AM, Certified Nursing Aide (CNA) #1 and CNA #2 were manually transferring Resident #32 from her bed to her wheelchair. The CNAs placed Resident #32 into her wheelchair on top of a lift pad that was positioned in the wheelchair. The CNAs did not use a mechanical lift during the transfer. During an interview on 4/21/24 at 11:01 AM, with CNA #1, she explained she was assigned to care for Resident #32 and had asked CNA #2 to assist with the transfer. CNA #1 confirmed they did not use a mechanical lift when transferring Resident #2 because she had good days and bad days, and today she was able to transfer manually with two (2) CNAs. They had placed the lift pad in the wheelchair in case she was unable to be transferred manually later and the evening shift would be able to use the mechanical lift if needed. CNA #1 explained the Kardex indicated the type of transfer that was required for the residents, and she verified that she did not look at the Kardex to determine how Resident #32 should have been transferred. During an interview on 4/21/24 at 11:13 AM, with CNA #2, she confirmed she assisted CNA #1 with manually transferring Resident #32 to her wheelchair from the bed without using a mechanical lift. CNA #2 explained that she was not familiar with Resident #32 and had assisted CNA #1 because she had asked for help. During an interview on 4/21/24 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, she confirmed the staff should have used the mechanical lift for the transfer. During an interview on 04/24/24 at 9:00 AM, the Director of Nursing (DON) confirmed the CNAs should have transferred Resident #32 with a mechanical lift and she stated expected the staff to transfer residents according to their physician orders. The DON explained Resident #32 recently had a decline and now required the use of the mechanical lift for transfers. A record Review of the Admission Record revealed the facility admitted Resident #32 on 5/10/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/24 revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on observation, staff interview, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated, mislabeled, exposed, expired, no identifying label, and spoiled produce for one (1) of two (2) kitchen observations. Findings Include: A review of the facility's policy, Food and Supply Storage, with an effective date of [DATE], revealed, Policy: Food and supplies will be stored under sanitary and secure conditions . Procedure: Food service products will be placed in appropriate storage . designated for each product .Food supplies must be dated .Rotation of stock/inventory .is essential to maintain quality . On [DATE] at 9:10 AM, an observation of the kitchen and interview with the Certified Dietary Manager (CDM), revealed the following: Refrigerator #1 contained one (1) casserole pan covered with aluminum foil and peas was handwritten on the foil, with no opened date. When the CDM removed the foil, he reported the contents as Chicken and Rice casserole. There were two trays containing portioned cups of what the CDM described as lemon pudding, with no date or label on the tray, and (1) of the cups was uncovered and exposed. There was (1) opened container of low sodium beef base, dated ,d+[DATE] and a manufacturer's best by date of [DATE]. There were 11 portioned cups of what the CDM described as pureed desserts, dated ,d+[DATE], with no identifying label. There was an opened bag of what the CDM described as french toast sticks, dated ,d+[DATE]. There was one (1) opened bag of celery with manufacturer's best by date of ,d+[DATE] in which the celery had a brown discoloration on the ends of the stalks and there were two other unopened bags of celery with a manufacturer's use by date of [DATE]. There was one (1) unopened bag of green onions with a manufacturer's best by date of [DATE]. There was one (1) box of lettuce with a manufacturer's delivery date of ,d+[DATE] in which the lettuce was spoiled. There was one (1) opened bag of cabbage, dated ,d+[DATE], one (1) unopened bag of coleslaw mix, undated, and one (1) unopened bag of coleslaw mix dated , d+[DATE]. There were also two (2) unopened bags of coleslaw mix with a delivery date of [DATE] and a manufacture's best if used by date of [DATE]. There was one (1) tray of unlabeled and undated portioned liquids of what the CDM described as thickened liquids, containing what the CDM described as three (3) waters, five (5) teas, two (2) apple juice one (1) orange juice. An observation of the pantry revealed the dry bin containing sugar was opened which left the sugar exposed. During the observation and interview, the CDM acknowledged the foods observed in the refrigerator did not have identifying labels, were undated, and expired and the sugar in the pantry was exposed. The CDM that he was responsible for discarding expired foods and the expired and spoiled foods observed should have been discarded. He also explained that he was responsible for labeling food items when delivered to the facility. Whoever opened a food item was responsibility for labeling and storing that item. The CDM reported the kitchen staff receive training every three (3) months regarding kitchen practices. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:54 AM, an interview with Cook #1 revealed everyone was responsible for labeling and dating foods when opened and the CDM was responsible for labeling foods items upon delivery. The cook reported that all staff are responsible for inspecting the foods daily for expiration dates and confirmed the staff receive in-service training monthly regarding food safety. On [DATE] at 3:54 PM, in an interview with the Administrator, she acknowledged she was aware there were improperly stored food items found in the kitchen and she expected all food to be properly dated and labeled and not mislabeled. She stated she expects to have no expired or spoiled foods items stored in the kitchen.