STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255351	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Senior Care	302 Ellis Street Carthage, MS 39051

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** 37399 47157 Based on observation, staff interview, record review, and facility policy review the facility failed to implement a care plan related to splinting devices for Resident #17 and develop a care plan for a resident with limited range of motion requiring splinting devices for Resident #26 for (2) two of 16 care plans reviewed. Findings include: Resident #17 Review of the facility policy titled, Comprehensive Care Plans, undated, revealed Policy: It is the policy of the 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 . Policy Explanation and Compliance Guidelines: .5. The comprehensive care plan will be reviewed . by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment . Record review of the facility policy titled, Prevention of Decline in Range of Motion, implemented 10/2023, revealed .Policy Explanation and Compliance Guidelines .3. Appropriate Care Planning: a. Based on the comprehensive assessment, the facility will provide interventions, exercises and /or therapy to maintain or improve. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes but is not limited to: .ii. Appropriate equipment (braces or splints). Record review of the care plan with a date initiated of 6/10/21 revealed Focus: Resident requires assistance . r/t (related to) right sided weakness and deformities to hand .Goal: Needs will be met every shift . Interventions/Task .Palm protector to right hand during waking hours with a date initiated for the intervention of 1/2/23. During an observation on initial tour on 5/06/24 at 10:15 AM and again at 3:56 PM, revealed Resident #17 had contractures of her right hand with no splints noted. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 05/07/24 at 10:10 AM, revealed Resident #17 in bed. There was no splint on her right hand and no splint observed in the resident's room. An observation and interview on 5/7/24 at 10:55 AM, with Licensed Practical Nurse (LPN) #1 confirmed the resident did not have the palm splint on as ordered. She stated the purpose of the splint is to prevent worsening of her contracture. An interview, on 5/07/24 at 11:05 AM with Registered Nurse (RN) #1 revealed the Certified Nursing Assistants are responsible for putting splints on and the nurses check on them. An observation and interview on 5/08/24 at 10:33 AM, with the Director of Nursing (DON) confirmed Resident #17 did not have her palm protector in her right hand. He stated that he did not know why but would find out. He stated he thought they took care of that yesterday. An interview on 5/08/24 at 10:36 AM, with the Occupational Therapist (OT) stated she had provided in-service education and made a notebook for the nurse's station to assist the staff with applying splints as they should be. The instructions included the physician order. Record review of the Order Summary Report with active orders as of 5/1/24 revealed an order dated 1/2/23 revealed, Resident to wear palm protector to right hand during waking hours d/t (due to) contracture/skin protection every day and evening shift for skin protection . An interview, on 5/09/24 at 9:20 AM, with the DON confirmed the resident had a care plan in place for application of the palm splint and confirmed that the care plan was not followed. Record review of the Admission Record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses that included Contracture, right hand. Resident #26 Record review of the Order Summary Report with active orders as of 5/7/24 revealed an order dated 6/3/21 Resident to wear splints to BIL (bilateral) hands for 1HR/DAY (one hour per day). Place splints on at 8 AM and take off at 9 AM . Review of the comprehensive care plans for Resident #26 revealed there was no care plan developed related to bilateral hand splint use. During a record review and interview with the DON on 5/07/24 at 9:50 AM, confirmed there was no care plan developed for the use of the hand splints for Resident #26. The DON confirmed the purpose of the comprehensive care plans is to direct the resident specific care needed. Record review of the Admission Record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses that included Contracture, unspecified wrist.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47157 Based on observation, staff interview, record review, and facility policy review the facility to revise a care plan for a resident who had limited range of motion and required splinting devices for (1) one of 16 care plans reviewed. Resident #26 Findings include: Review of the facility policy titled, Comprehensive Care Plans, undated, revealed Policy: It is the policy of the facility to . implement a comprehensive person-centered care plan for each resident . Policy Explanation and Compliance Guidelines: .5. The comprehensive care plan will be .revised . by the interdisciplinary team . Record review of the care plan with a revision date of 4/8/24 revealed, Focus Total care required with ADLs (activities of daily living) R/T (related to) immobility , meds (medications), weakness, contracture to left elbow, quadriplegia .Interventions/Tasks Apply splint to left elbow daily for 30 minutes to prevent further contracture and improve range of motion/skin integrity . An observation on 5/6/24 at 10:15 AM, revealed Resident #26 sitting in the lobby watching TV no splints noted to left elbow contracture. Record review of the Order Summary Report with active orders as of 5/7/24 revealed an order dated 9/22/23, .Patient to wear . left elbow brace . for 4-6 hours during 3-11 shift. 7 x (times) a week to help prevent risk of further contractures . An interview with the Director of Nursing (DON) on 5/07/24 at 9:50 AM, confirmed after review of the care plans for Resident #26 there was no revision of the care plan for the elbow brace when the order was changed on 9/22/23 for the resident to wear the brace for 4-6 hours. The DON confirmed the purpose of the comprehensive care plans is to direct the resident's specific care needed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37399 47157 Based on observation, resident, Resident Representative (RR), and staff interview, record review, and facility policy review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for (2) two of (9) nine residents with splinting device orders. (Resident #17 and #26) Findings include: Record review of the facility policy titled, Prevention of Decline in Range of Motion, implemented 10/2023, revealed, .Policy Explanation and Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care . Record review of the facility policy titled, Transcribing Physician Orders, undated, revealed Policy: It is the policy of the facility to transcribe and follow the attending physician's orders as written with order clarification when needed. Procedure: .Transcription will be carried out to appropriate administration record. i.e. (example) MAR (Medication Administration Record) and TAR (Treatment Administration Record) . End of month printing will take place and all MARs, TARs, and physicians orders will be reviewed for accuracy. Any new orders written will be put on the 24 hour report that is reviewed by the RN (Registered Nurse) unit manager and/or the DON (Director of Nursing) daily. Record review of the facility policy Splint Application dated 10/23 revealed Policy: It is the policy of this facility that splint application will be done based on referral and recommendation of therapy department. Procedure: Splint will be applied per recommendations of therapy and physician order .Documentation of splint application will be done on the Treatment Administration Record. Resident #17 On initial tour observations at 10:30 AM on 5/06/24 and again at 3:56 PM, revealed a contracture of Resident #17's right hand with no splint in place. During an observation on 5/07/24 at 10:10 AM, revealed Resident #17 in bed with no splint on her right hand and no splint was observed in the resident's room. An observation and interview, on 5/7/24 at 10:55 AM, with Licensed Practical Nurse (LPN) #1 confirmed the resident did not have the palm splint on as ordered. LPN #1 searched the resident's room, storage closets, and laundry and was unable to locate the resident's splint. LPN #1 stated that the splint should be in the resident's bedside table drawer. She stated the purpose of the splint is to prevent worsening of her contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview, on 5/07/24 at 11:05 AM with Registered Nurse (RN #1) revealed the Certified Nursing Assistants (CNA) are responsible for putting splints on and the nurses check on them. An interview, on 5/07/24 at 11:20 AM with CNA #1 confirmed she was assigned to Resident #17. She stated that after she completed the resident's care this morning she could not find the splint. She stated that she should have let the nurse know she could not find the splint , but she had not seen the nurse. An observation and interview, on 5/08/24 at 10:33 AM, with the Director of Nursing (DON) confirmed Resident #17 did not have her palm protector in her right hand. He stated that he did not know why, but would find out. He stated he thought they took care of that yesterday. An interview, on 5/08/24 at 10:36 AM, with the Occupational Therapist (OT) revealed she had not completed a recent assessment on Resident #17. She stated that she had provided in-service education and made a notebook for the nurse's station to assist the staff with applying splints as they should be. The instructions included the physician order. Record review of the Order Summary Report with active orders as of 5/1/24 revealed an order dated 1/2/23, Resident to wear palm protector to right hand during waking hours d/t (due to) contracture/skin protection every day and evening shift . Record review of the Admission Record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses that included Contracture, unspecified wrist. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 4/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 01, indicating Resident #17 has severe cognitive impairment. Resident #26 An observation on 5/6/24 at 10:15 AM, revealed Resident #26 sitting in the lobby watching TV no splints noted to bilateral hands or left elbow contracture. An interview with Resident #26's Resident Representative (RR) on 5/6/24 at 3:45 PM, stated she was worried Resident #26's contractures to his hands and left arm were getting worse because the staff were not putting his splints on. She stated she has brought it to nurses' attention several times, but they are never on when she comes to visit. Resident #26's RR then asked Resident #26 if the staff put his braces on him every day and he shook his head back and forth indicating no and in a very low toned voice said no. Resident #26 was observed to have no splinting devices in place to hands or elbow areas. Record review of the Order Summary Report with active orders as of 5/7/24 revealed an order dated 6/3/21 Resident to wear splints to BIL (bilateral) hands for 1HR/DAY (one hour per day). Place splints on at 8 AM and take off at 9 AM . Record review of the Order Summary Report with active orders as of 5/7/24 revealed an order dated 10/18/22, Apply Splint to left elbow daily for 30 minutes to prevent further contracture and improve ROM (range of motion)/skin integrity (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Order Summary Report with active orders as of 5/7/24 revealed an order dated 9/22/23, .Patient to wear left sheepskin palmar splint, left elbow brace, and right soft comfy hand/wrist splint for 4-6 hours during 3-11 shift. 7 x (times) a week to help prevent risk of further contractures . An observation on 5/07/24 at 8:30 AM, revealed resident with no splints to bilateral hands or left elbow. No splints were observed in the room. An observation on 5/07/24 at 9:35 AM, revealed no splinting devices noted to bilateral hands or left elbow. An interview with LPN #2 on 5/07/24 at 9:36 AM, revealed she was assigned to Resident #26 and confirmed she had not applied his hand splints today but knew they were scheduled to be applied from 8:00 AM -9:00 AM. She state she was going to put them on after she finished her medication pass. She also revealed she was assigned to Resident #26 on 5/06/24 and confirmed she did not apply the splints to the resident's hands. During a record review of the physician orders and interview on 5/07/24 at 9:45 AM, with the Director of nursing (DON) revealed that the physician's orders for the splints for Resident #26 was incorrect revealing there were three (3) different orders. He stated the splint order dated 9/22/23 Patient to wear left sheepskin palmar splint, left elbow brace, and right soft comfy hand/wrist splint for 4-6 hours during 3-11 shift. 7 x (times) a week to help prevent risk of further contractures . was the correct order. He then confirmed staff would not have known to follow the physicians order for 9/22/23 to wear the splint 4-6 hours every evening because the order was not transcribed correctly and was not triggering to the TAR. He confirmed the previous 2 splint orders should have been discontinued because the order dated 9/22/23 superseded the previous splint orders. He then revealed all orders should also be reviewed during the 24-hour order check and monthly for accuracy but confirmed they need to do a better job at that. The DON stated with LPN #2 confirming she did not apply the splints and the days on the TAR not signed off as services provided then the staff did not provide the services per the active orders for splints. Record review of the April 2024 TAR for Resident #26 revealed (7) seven out of 30 days the TAR was not initialed with staff initials indicating the bilateral hand splints were applied as ordered, and (1) of 30 days with no initial that the splint to left elbow was applied. Review of the May 2024 TAR for Resident #26 revealed four (4) days from May 1st through 6th with no initials that bilateral hand splints were applied as ordered, and 1 day with no initial that the splint to the left elbow was applied. An interview with the Occupational Therapist (OT) on 5/07/24 at 10:15 AM, revealed she wrote the physician's order on 9/22/23 for the bilateral hands and left elbow splint to be applied for 4-6 hours every evening to prevent further contractures. She also stated she in-serviced the nursing staff on 9/18/23 and again on 4/24/24 on the specific splint application and duration for each resident requiring splints. She stated she was unaware that staff were not following the orders from 9/22/23. The OT then revealed that with staff not applying the splints as ordered it did place the resident at risk for worsening contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an In-service form dated 9/18/23 and 4/24/24, related to Resident #26 revealed Patient to wear left sheepskin palmar splint, left elbow brace, and right soft comfy hand/wrist splint for 4-6 hours during 3-11 shift to help prevent risk of further contractures. The inservice form was signed by LPN #2 and the DON. A follow-up interview with LPN #2 on 5/7/24 at 11:30 AM, revealed she was unaware of the changes in orders for Resident #26's splints. She confirmed they had in-services about splints and applying splints but just didn't realize the orders changed to 4-6 hours daily but confirmed staff were not even following the splint orders triggering to the TAR with all the days not signed off as completed . Record review of the Admission Record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses that included Contracture, unspecified wrist. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/24 revealed a Brief Interview for Mental Assessment (BIMS) score of 13 which indicated Resident #26 was cognitively intact.