STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallahatchie General Hosp Ecf	201 South Market St Charleston, MS 38921

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interview, record review and facility policy review, the facility failed to ensure resident information was not accessible to the public during medication administration for one (1) of four (4) residents observed during medication administration. Resident #82. Findings Include: Record review of the facility policy, Administration of Drugs with revised date of 09/08 revealed, .Medication Administration Records should be kept covered to ensure privacy of information An observation on 12/03/24 at 9:00 AM, of a medication cart on the A-Hall, revealed an open computer screen with Resident #82's Electronic Medication Administration Record (EMAR) information visible to anyone passing by the medication cart. The visible information included Resident # 82's name, medications, and room number. An interview on 12/03/24 at 9:10 AM, with Licensed Practical Nurse (LPN) #1 revealed that she was assigned to the medication cart on A-Hall. She confirmed that the EMAR for Resident #82 was visible on the computer screen and that she should have clicked the privacy screen on before she walked away from the cart. LPN #1 agreed that this was a privacy issue and that the resident's information in the medical record should be kept confidential. An interview on 12/03/24 at 9:55 AM, with LPN Supervisor revealed that the nurses were supposed to lock the computer screen prior to leaving the medication cart unattended. She revealed that the purpose of the locked screen was to prevent anyone who might be walking by from seeing a resident's personal health information. LPN Supervisor stated, It's always a given to lock the cart and have the privacy screen on while administering medicine. An interview on 12/03/24 at 10:05 AM, with Director of Nursing (DON) revealed that a resident's personal information should never be left up on the computer screen while the medication cart is unattended. She revealed that there was a privacy button that was supposed to be pushed before the nurse stepped away from the computer. The DON confirmed that this was a privacy issue and that residents information should be kept confidential. Record review of Resident #82's Admission Record revealed an admitted [DATE].

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47874 Based on staff interview, record review, and facility policy review, the facility failed to accurately complete a section of the Minimum Data Set (MDS) for a resident with significant weight loss for one (1) of 22 sampled residents MDS reviewed. Resident #6 Findings Include: Review of the facility policy titled Resident Assessment Instrument (RAI) revised September 2010, revealed under, Policy Interpretation and Implementation: . 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning . 7. All persons who have completed any portion of the MDS Resident Assessment Form must sign such document attesting to the accuracy of such information. Record review of the Weight Summary for Resident #6 revealed the following values: 7/2/2024 176.6 Lbs. 7/8/2024 175.2 Lbs. 7/17/2024 173.6 Lbs. 7/24/2024 169.2 Lbs. 8/13/2024 169.2 Lbs. 9/5/2024 158.0 Lbs. 10/2/2024 157.6 Lbs. 10/9/2024 156.4 Lbs Record review of the Registered Dietician (RD) Assessment Summary dated 9/13/24 for Resident #6 revealed under, Weight changes: (minus) -6.6 % (percent) SWL (significant weight loss) x (times) 30 days . Record review of the Weight Note for Resident #6 dated 9/26/24 revealed the resident had an 11.2-pound weight loss in 30 days. Record review of Resident #6's Quarterly MDS, with an Assessment Reference Date (ARD) of 10/9/24, revealed under section K0300, loss of 5% (percent) or more in the last month or loss of 10% (percent) or more in last 6 months was answered and marked as No. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS Nurse on 12/3/24 at 2:25 PM, confirmed that section K was not completed accurately to reflect Resident #6's weight loss. She revealed the Dietary Manager (DM) was responsible for completing that section of the MDS and confirmed that it was missed. An interview with the DM on 12/3/24 at 3:06 PM revealed, she made a mistake completing Resident #6's section K and explained that she did not go back and look at the weights like she should have. She confirmed if the MDS was not completed accurately, it would not reveal the complete needs of the resident's health status. An interview with the Director of Nursing (DON) on 12/3/24 at 3:20 PM revealed her expectations were for all sections of the MDS to be completed accurately. Record review of the Admission Record revealed the facility admitted Resident #6 on 7/2/24 with medical diagnoses that included Unspecified Dementia and Heart Failure.

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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 reviews, and facility policy reviews, the facility failed to develop and implement an Activities of Daily Living (ADL) comprehensive care plan for residents' hygiene, grooming, and nail care for two (2) of 19 sampled residents. Resident #38 and Resident #147 Findings include: Record review of the facility policy titled Care Plans, Comprehensive Person-Centered with a revision date of December 2016 revealed under Policy Statement: 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. Resident #38 Record review revealed a care plan revised on 9/26/24 for Resident #38 with a focus on ADL's/Falls/Pain: I have impaired physical functioning and require assistance with ADL's related to chronic pain and (Right) R-sided Hemiplegia. The care plan for the resident with impairments has no personal hygiene, grooming, or nail care interventions. On 12/02/24 at 2:10 PM, an observation of Resident #38's nails revealed bilateral fingernails were approximately one-half (1/2) inch long and jagged with a brown substance under the nails. On 12/03/24 at 10:45 AM, an observation and interview with Certified Nurse Aide (CNA) #1 revealed the CNAs were responsible for doing Resident #38's nail care. CNA #1 confirmed that Resident #38's fingernails were long and had a brown substance under them, revealing they needed to be cleaned and trimmed. During an interview on 12/04/24 at 11:35 AM, the Director of Nurses (DON) revealed that the purpose of the care plan is to indicate the resident's individualized care that is needed for that resident, so the staff will know the resident's needs. She confirmed that the care plan was not developed to reflect Resident #38's hygiene or grooming needs, which included nail care. Record review of Resident #38's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Vascular Dementia, Depressive disorders, and Hemiplegia and Hemiparesis following Cerebral infarction. 41878 Resident #147 Record review of the care plan for Resident #147 date initiated 11/25/24 revealed, Focus: ADLs .I have impaired physical functioning and require assistance with ADLs . This care plan did not address bathing, hygiene, grooming, or nail care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/02/24 at 10:25 AM, during an observation and interview, Resident #147 revealed she would like her nails to be trimmed. She stated she had never had long nails, and she preferred her nails to be kept short. Observation of her nails revealed seven (7) of her 10 nails were long with the thumb nails approximately 3/4 inch long and some of her nails were jagged and rough. During an interview on 12/3/24 at 11:20 AM, the DON stated the purpose of the care plan was to drive the resident's individualized plan of care and to inform staff of the care that was needed. She confirmed the facility failed to develop an ADL care plan for this resident's nail care. During an interview on 12/3/24 at 3:30 PM, the Minimum Data Set (MDS) Coordinator Registered Nurse revealed she was responsible for the development of the care plans and the purpose of the care plan was to give the staff information on the needed care and preferences for each resident. She confirmed the facility failed to develop the care plan for ADL nail care for Resident #147. Record review of Resident #147's Admission Record revealed the facility admitted the resident on 11/12/24 with diagnoses of Stress Fracture to right ankle and Hypertension. Record review of Resident #147's MDS with Assessment Reference Date (ARD) of 11/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had a moderate cognitive impairment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide care to maintain personal hygiene, as evidenced by the failure to provide nail care for two (2) of nineteen sampled residents. Resident #38 and Resident #147 Findings include: A review of the facility policy titled Fingernails/Toenails, Care Of revised 09/08 revealed Purpose: . To clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care cleaning should be done daily. Resident #38 An observation on 12/02/24 at 2:10 PM of Resident #38's nails revealed bilateral fingernails were approximately one-half (1/2) inch long and jagged with a brown substance under the nails. An observation on 12/03/24 at 9:03 AM and again at 10:30 AM revealed Resident #38's fingernails on bilateral hands remained long and jagged with a brown substance under the nails. An observation and interview on 12/03/24 at 10:45 AM, Certified Nurse Aide (CNA) #1 revealed the CNAs are responsible for doing Resident #38's nail care. She revealed we do the nail care when we see that it needs to be done and confirmed that the resident's fingernails were long and had a brown substance under them, revealing they needed to be cleaned and trimmed. An observation and interview on 12/03/24 at 11:05 AM, the Director of Nurses (DON) confirmed that Resident #38's fingernails needed cleaning and trimming and revealed that this could cause skin concerns for the resident. Record review of Resident #38's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Vascular Dementia, Depressive disorders, and Hemiplegia and Hemiparesis following Cerebral infarction affecting right dominant side. 41878 Resident #147 During an observation and interview on 12/02/24 at 10:25 AM, Resident #147 revealed she would like her nails to be trimmed. She stated she had never had long nails and she preferred her nails to be kept short. Observation of her nails revealed seven (7) of her 10 nails were long with thumb nails approximately 3/4 inch long and some of her nails were jagged and rough. An interview with Registered Nurse (RN) #1 with an observation of Resident #147's nails on 12/3/24 at 10:25 AM, revealed the resident's long and rough nails. The resident informed RN #1 that she preferred to have short nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 11:20 AM, the DON revealed each resident's nails should be maintained as the resident preferred and since this resident preferred short nails, the staff should ensure they are kept clean and short. Record review of Resident #147's Admission Record revealed the facility admitted the resident on 11/12/24 with a diagnosis of Stress Fracture to right ankle. Record review of Resident #147's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had a moderate cognitive impairment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45598 Based on observation, staff interview, and facility policy review, the facility failed to properly secure medications as evidenced by leaving a medication cart unlocked for one (1) of four (4) medication administration observations. Findings include: Record review of the facility policy, Storage of Medications with revision date of 09/08 revealed, Purpose: Is to ensure that medications are stored in a safe, secure, and orderly manner .Compartments containing medications are locked when not in use. Carts used to transport such items are not left unattended. (Compartments include .drawers, cabinets, rooms, refrigerators, carts . An observation on 12/03/24 at 9:45 AM, with Licensed Practical Nurse (LPN) #1 revealed an unlocked medication cart left unattended on A-Hall during administration of a resident's medications. At 9:48 AM, LPN #1 revealed that she was assigned to the medication cart on A-Hall and confirmed that she did not lock the medication cart and stated, I don't usually lock it. LPN #1 confirmed that she should have locked the medication cart prior to walking away to prevent others from taking medications out of the cart. An interview on 12/03/24 at 9:53 AM, with LPN Supervisor, revealed that the medication carts should always be locked when unattended to prevent others from opening the drawers and taking the medications. She stated, It's always a given to lock the carts .and they all know this. An interview on 12/03/24 at 10:03 AM, with Director of Nursing (DON), revealed that the medication carts should always be locked when unattended to keep the medications secure and for safety reasons. She revealed that LPN #1 should have locked the medication cart before she walked away from it to keep the medications secure.