STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255284	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	3103 WISCONSIN AVENUE VICKSBURG, MS 39180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 03/11/24 through 03/14/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F583, F584, F640, F656, F658, F677, F759 and F921. The census at the time of the survey was 56 and the facility is licensed for 60.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		4/11/24

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

Electronically Signed | 03/22/2024

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F 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to secure electronic health records as evidenced by an Electronic Medication Record (EMAR) was visible on an unattended medication cart on the 200 hall for one (1) of 56 residents residing in the facility during survey. Resident #19 Findings include: Review of the facility policy with a revision date of 06/13 titled "Electronic Health Records" revealed, "It is the policy of this facility to use electronic health records (EHR). Electronic signatures may also be used on EHR as permitted by CMS (Centers for Medicare and Medicaid Services) and state laws ... Safeguards in place to minimize improper usage include the following measures ...Privacy screen enabled. Workstations are secured with a password protected automatic inactivation feature set at three (3) minutes or less in which the workstation locks when not in use." An observation on 03/12/24 at 8:50 AM of a computer that was located on a medication cart on the 200 hall revealed the computer was opened with Resident #19's EMAR information	F 583	F583 Personal Privacy/Confidentiality of Records Facility failed to secure electronic records as evidenced by an Electronic Medication Record (EMAR) was visible on an unattended medication cart on the 200 hall for one (1) of 56 residents residing in the facility during survey. 1. Director of Nursing was notified on 3/12/24 of the deficient practice by Licensed Practical Nurse #1. Director of Nursing completed an assessment of Resident #19 on 3/12/24 which showed no adverse effects in regards to privacy. Director of Nursing completed a one-on-one written education with Licensed Practical Nurse #1 on 3/12/24 regarding policy and procedures regarding privacy of resident□s medical record. 2. All fifty-six (56) residents currently residing in the 60 bed facility that receive medical care have the potential to be affected by this deficient practice. 3. An in-service was initiated by the	

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F 583	Continued From page 2 visible on the screen. Licensed Practical Nurse (LPN) #1 was in Resident #19's room and the screen was visible to anyone that walked by the medication cart. The visible information included Resident #19's name, medications, room number, and diagnoses. An interview on 03/12/24 at 8:55 AM, with LPN #1 confirmed that she left the laptop computer open with Resident #19's EMAR up on the screen visible to anyone that walked by. LPN #1 confirmed that there is a privacy button that she should have pushed before leaving the cart and that leaving the screen open could result in a security violation. LPN #1 stated "we have been trained on using the privacy button any time we are not standing in front of the computer". An interview on 03/12/24 at 3:20 PM, with the Director of Nursing (DON) confirmed that a resident's information should never be left up on a screen and that there is a privacy button that the staff member is supposed to push prior to walking away from the computer. The DON confirmed that leaving the information up is a privacy issue and could result in a Health Insurance Portability and Accountability Act (HIPPA) violation. A review of the facility "Face Sheet" for Resident #19 revealed that the resident was admitted to the facility on 11/17/15 with medical diagnoses that included Vascular dementia and Hemiplegia.	F 583	Administrator and Director of Nursing with licensed nurses and facility staff that utilize electronic medical devices for charting on the Electronic Health Records policy in regards to privacy on 3/12/2024. Upon hire, annually and as needed all staff that utilize electronic devices to chart medical information are trained on privacy in regards to Electronic Health Records. 4. Director of Nursing, RN Supervisor or Staff Development Nurse will monitor for compliance with electronic devices for privacy practices beginning March 19, 2024 at least 3 x weekly for 4 weeks then 1 x weekly for 4 weeks if no other problems identified. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and monthly x 2 months to discuss findings from annual survey in reference to Electronic Medical Records privacy. Director of Nursing, Administrator or Staff Development Nurse will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as: Individual in services, re-in-service, or disciplinary action up to an including termination of employees and initiate Quality Assurance and Performance Improvement (QAPI) if	

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F 583	Continued From page 3	F 583	warranted. QAPI committee will implement corrections or changes as needed.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		4/11/24

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to provide resident rooms that are in good repair as evidenced by broken blinds, missing base molding and peeling sheetrock for two (2) of 36 resident rooms observed during survey. Findings Include. A review of the facility policy with a last revision date of 06/13, titled " Repair Requisition" revealed, "...Procedure: 1. When a resident, staff member, or family member recognizes the need for maintenance services, a Repair Requisition form (AD-022) will be completed by a resident, a family member, or a staff member. 2. The completed form will be placed in a mailbox or other designated place for maintenance personnel. 3. Maintenance personnel will review all Repair Requisitions daily and prioritize work to be done...All Repair Requisitions will be followed up on..." An observation on 03/11/24 at 2:00 PM, of room #210 revealed that the blinds on the window facing the outside of the facility were missing approximately four (4) slats between the bottom of the window to the middle of the window. An observation on 03/12/24 at 10:42 AM, of room	F 584	F584 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT 1.Facility failed to provide resident rooms that are in good repair as evidenced by broken blinds, missing base molding and peeling sheetrock for two (2) of 36 resident rooms observed during survey. 1. Residents in room 210 and room 208 were assessed with no adverse effects regarding broken blinds and floor issues. Resident room #210 blinds were replaced on 3/12/2024. Floor molding ordered, received and repaired on 3/22/24. 2. All fifty-six (56) residents residing in the facility have the potential to be affected by this deficient practice. 3.In-service initiated with all staff on 3/20/24 by Administrator regarding repairs and maintenance observations and notification of repair process to ensure home like environment for all residents. On March 12 the Department Heads will have designated rooms for daily rounds that include repair and maintenance	

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F 584	Continued From page 5 # 208 revealed that the wall separating the bathroom and the residents' room is missing a corner molding at the floor with peeling sheetrock underneath. An interview and observation on 03/12/24 at 2:00 PM, with Licensed Practical Nurse (LPN) #1, confirmed that room #210 is missing approximately 4 slats from the base of the window to the middle of the window. LPN #1 confirmed that the blinds being broken doesn't provide a comfortable homelike environment. An interview and observation on 03/12/24 at 2:10 PM, with the Administrator confirmed that the blinds in room #210 need to be replaced and are missing approximately 4 slats. The Administrator confirmed that with the blinds broken that it does not provide a homelike environment. An interview on 03/12/24 at 3:39 PM, with the Maintenance Director confirmed that if staff sees something wrong in a resident's room that they should log it on the maintenance clipboard and nobody had made him aware of the baseboard or the missing blinds. The Maintenance Director confirmed that the clipboard is located at the nursing station and that he checks it when he gets to work at 8:00 AM, throughout the day and before he leaves at 5:00 PM. An interview on 03/12/24 at 4:05 PM, with LPN #1 confirmed that the baseboard molding on the wall between the bathroom and resident room in room #208 is missing a corner molding at the floor and needs to be placed on the maintenance log and repaired. LPN #1 confirmed that with the baseboard molding missing it does not provide a clean, homelike environment.	F 584	observations and notification for repairs to ensure home like environment for all residents. 4. Administrator and/or supervisor will monitor resident rooms in regards to maintenance needed repairs beginning March 22, 2024 at least 3 x weekly x 4 weeks and then 1 x weekly x 4 weeks if no recurring problems identified. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and monthly x 2 months if needed to discuss findings from annual survey in reference to safe homelike environment. Administrator and Supervisor will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as: Individual In-services, re-In-service, or disciplinary action up to and including termination of employees, and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI Committee will make recommendations or changes as needed.	

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F 584	Continued From page 6 An interview on 03/12/24 at 4:10 PM, with Certified Nursing Assistant (CNA) #3 confirmed that the molding was missing in room 208 between the bathroom and the resident room. CNA #3 confirmed that if the staff sees something wrong or sees something that needs to be fixed in a resident's room that they are supposed to log it on the maintenance clip board. CNA #3 confirmed that the clipboard is located at the nurse's desk.	F 584		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		4/11/24

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F 640	Continued From page 7 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to transmit a discharge Minimum Data Set (MDS) Assessment for one (1) of two (2) residents reviewed for discharge MDS assessments. Resident #10 Findings Include Review of the facility policy titled, "CH (Chapter) 5: Submission and Correction of the MDS Assessments" dated October 2023 revealed, "5.2 Timeliness Criteria ...Encoding Data: For a...Discharge...assessment, encoding must occur	F 640	F640 ENCODING/TRANSMITTING RESIDENT ASSESSMENTS The facility failed to transmit a discharge Minimum Data Set (MDS) Assessment for one (1) of two (2) residents reviewed for discharge MDS assessments Resident #10 1. On 3/14/24 the facility Nurse Case Manager completed a Discharge Return not Anticipated Minimum Data Set (MDS) on Resident #10 and was transmitted on 3/14/24 to the Internet Quality	

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F 640	Continued From page 8 within 7 days after the MDS Completion Date (Z0500B + 7 days)". Record review of Resident #10's "Face Sheet' revealed an admit date of 7/17/23 and a discharged date of 10/24/23 with a "Discharge Status of Return not anticipated". A record review of the "MDS 3.0 NH (Nursing Home) Final Validation Report" for Resident #10 with a target date of 10/24/2023 revealed a discharge assessment from Medicare Part A services and no "MDS Discharge Return not Anticipated" assessment. An interview on 03/13/24 at 2:58 PM, the MDS Coordinator revealed Resident #10 was discharged home on 10/24/23. She confirmed the resident's MDS discharge from Part A services was submitted on 10/24/23 however the resident was also discharged from the facility on 10/24/23 with a return not anticipated. She confirmed the discharge return not anticipated MDS data was not submitted and therefore her discharge MDS assessment record is now over 120 days late. She revealed this was an unintentional error.	F 640	Improvement and Evaluation System (QIES). Resident # 10 was discharged from facility on 10/24/23. 2. All fifty-six (56) residents that may discharge from the facility have the potential to be affected by this alleged deficient practice. 3. On 3/14/24, the facility Nurse Case Manager reviewed all facility discharges that warrant a need for Discharge Return not Anticipated Minimum Data Set (MDS) with no issues noted. On 3/14/24 Nurse Case Manager and Assessment Nurses were in-serviced on Resident Assessment Policy by the Director of Nurses. 4. Beginning on 3/15/24, the Director of Nursing and/or Nurse Case Manager will review discharges to determine need for completion of Discharge Return not Anticipated Minimum Data Set (MDS) at least 3 x week x 4 weeks and then 1 x week x 4 weeks if no new issues identified. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and monthly x 2 months if needed to discuss findings from annual survey in reference to Electric Medicare Records privacy. The Director of Nursing will report any recurring issues identified to the Quality Assessment Improve Committee.	

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F 640	Continued From page 9	F 640	Administrator and Director of Nursing will take necessary correction action such as: Individual in services, re-in-service, or disciplinary action up to and including termination of employees, and initiate a Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI committee will make recommendations and changes as needed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		4/11/24

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F 656	Continued From page 10 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to develop a care plan related to resident facial hair for Resident #3 and Resident #40 or implement a care plan for Resident #43 related to administering medications one at a time, with a flush between each medication through a percutaneous endoscopic gastrostomy (PEG) tube for three (3) of 18 resident care plans reviewed. Findings Include Record review of the facility policy titled "Care Plan Process" with a revision date 08/17, revealed "Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive standardized assessment of each resident's functional capacity and needs, in	F 656	F656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN The facility failed to develop a care plan related to resident facial hair for Resident #3 and Resident #40 or implement a care plan for Resident #43 related to administering medications one at a time, with a flush between each medication through a percutaneous endoscopic gastrostomy (PEG) tube for three (3) of 18 resident care plans reviewed. 1. Director of Nursing was notified of this deficient practice on 3/12/2024. Immediately following notification, the Director of Nursing, instructed the Certified Nursing Assistance to perform ADL care in reference to shaving for both	

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F 656	Continued From page 11	F 656		

relation to a number of specified areas (e.g., customary routine, vision, and continence ... The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs..."

Resident #3

Record review of the care plans for Resident #3 revealed, "Problem onset: dated 05/15/2020, Resident needs partial to extensive assists with ADL's (Activities of Daily Living) related to weakness/history of falls. Under Approaches, there were no approaches reflected for Resident #3's personal hygiene.

During an observation on 03/12/24 at 8:07 AM and again at 12:05 PM, revealed Resident #3 had facial hair approximately one-half (1/2) inch long to her chin area and beside her mouth.

An interview and observation on 03/12/24 at 3:55 PM with Certified Nurse Aide (CNA) #1 revealed the aides are responsible for bathing their residents which also includes oral care and shaving.

A record review of Resident #3's "Face sheet" revealed the resident was admitted to the facility on 10/18/19 with medical diagnoses that included Peripheral vascular disease and Vitamin deficiency.

Resident #40

Record review of the care plans for Resident #40 revealed under, "Problem onset: dated 05/11/2023, Resident needs partial to extensive assistance with ADL's. Under Approaches, there

residents. The Director of Nursing also assessed resident #3 and Resident #40 with no adverse effects from this deficient practice.

Upon notification of the deficient practice, the Director of Nursing immediately assessed resident #43 with no adverse effects from deficient practice. The Director of Nurses completed a one-on-one education with Register Nurse #1 regarding policy for administering medications through nasogastric or gastrostomy tube with emphasis on policy and procedure #7 (check placement, flush before administering medications and administer each crushed medication separately with 5cc of water between each medications followed by flushed when finished) # points to remember #1 (use gravity when giving medications or flushing tube) and #8 (flush with 30cc of water per MD order before and after giving meds, flush with 5cc between each medications) . Director of Nursing also initiated an In-service with all nursing staff on March 18, 2024 regarding the policy of administering medications through nasogastric or gastrostomy tube.

2. All fifty-six (56) residents have the potential to be affected by this deficient practice.

3. In-service initiated on March 21, 2024 by the Director of Nursing and Staff Development Nurse for all licensed staff and certified nursing staff regarding Care Plans, and emphasis on following the

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HERITAGE HOUSE NURSING CENTER	3103 WISCONSIN AVENUE VICKSBURG, MS 39180

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F 656	Continued From page 12 were no approaches reflected for Resident #40's personal hygiene. During an observation on 03/12/24 at 9:35 AM and again at 12:00 PM, Resident #40 had facial hair approximately 1 inch long to her chin and above her upper lip. An interview on 03/12/24 at 3:25 PM, CNA #2 revealed the CNAs on the day shift rotation are responsible for shaving residents if they need it, she revealed it's usually done when they first wake up and do their baths or oral care. A record review of Resident #40's "Face Sheet" revealed the resident was admitted to the facility on 1/08/24 with medical diagnoses that included Acute kidney failure and Hypercalcemia. An interview on 03/12/24 at 04:35 PM, the Minimum Data Set (MDS) Coordinator revealed the care plan is developed so the staff will know what care the resident needs, and it should be specific to their individual needs. She confirmed the ADL care plan for Resident #3 and Resident #40 was not developed to include the residents' specific hygiene ADL care and it should have been. She revealed these care plans are not what we would like to see and it would get fixed. Resident #43 Record review of Resident #43's "Care Plan" with an onset date of 12/24/2021, revealed under, "Approaches: ... Flush PEG w/ [with] 30 CC [cubic centimeters] of H20 [water] before and after med [medication] administration and w/ [with] 5 [five] CC [cubic centimeters] of H20 [water] between each med [medication]."	F 656	individualized plan of care for each resident and updating care plans according to resident needs and preferences. Upon hire, annually and as needed all nursing staff are provided education on following care plan, updating and addressing care plans so that they are individualized to each resident. An in-service was initiated for all licensed nursing staff and certified nursing assistant's on 3/13/24 by the Staff Development Nurse regarding performance of AM care with all residents with emphasis on shaving of residents daily. 4. The Director of Nursing, Staff Development and RN Supervisor will monitor ADL care for residents with emphasis on following care plan in regards to evaluating for facial hair beginning March 19, 2024 for at least 3 x weekly for 4 weeks and then 1 time a week for 4 weeks if no other problems identified. The Director of Nursing, Staff Development Nurse and Pharmacy Consultant will monitor medication administration regarding nasogastric or gastrostomy tube with emphasis on following care plan in reference to policy and procedure for administering medications March 18, 2024 for at least 3 x weekly for 4 weeks then one time weekly for 4 weeks if no other problems	

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F 656	Continued From page 13 During an observation with Registered Nurse (RN) #1 during medication pass on 3/13/2024 at 8:12 AM, revealed he prepared and crushed together the following medications: Fenofibrate (cholesterol reducer), Pepcid (stomach acid reducer), Sinemet (Parkinson's symptoms) and Sodium Bicarb (bicarbonate) (neutralizes stomach acid). RN #1 then administered the mixed medications to Resident #43 by PEG tube by pushing the end of the syringe. During an interview with RN #1 on 3/13/2024 at 8:30 AM, confirmed he did not crush and administer each medication separately. He stated he was allowed to give Resident #43's meds together because they were compatible, and stated he had a physician order to do so. During an interview with the Director of Nursing (DON) on 03/13/2024 09:20 AM, confirmed Resident #43 did not have a physician order to administer PEG medications crushed together. An interview with the Minimum Data Set (MDS) Coordinator on 3/14/2024 at 8:14 AM revealed the purpose of the care plan was to notify the staff of what individualized care the resident needs. She confirmed Resident #43's care plan was not followed related to medication administration. Record review of the "Face Sheet" revealed the facility admitted Resident #43 on 8/20/2020 with medical diagnoses that included Parkinson's disease and Dysphagia.	F 656	identified. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and monthly x 2 months if needed to discuss findings from annual survey in reference to care plans. Administrator and Supervisor will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as: Individual Inservice□s, re-Inservice, or disciplinary action up to and including termination of employees, and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI Committee will make recommendations or changes as needed.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/11/24

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F 658	Continued From page 14 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow professional standards of practice for a feeding tube as evidenced by crushing and administering multiple medications at once without the use of gravity and failure to follow physician orders for water flushes for one (1) of five (5) residents observed during medication administration. Resident #43 Findings include: Review of the facility policy titled "Administering Medications Through Nasogastric or Gastrostomy Tube" with a revision date of 03/2018 revealed under, "...Procedures: ... 7. After verifying proper placement of tube, flush it with a least 30 cc [cubic centimeters] of water before administering medications. Administer each medication separately, mix crushed medication with 5 (five) cc of water and flush the feeding tube with at least 5 cc of water between medications unless fluids are restricted." Also revealed under, "Points To Remember: 1. When administering medication or flushing tube with water, use gravity (syringe without plunger) ... 8. ... Flush with 5 cc of water between medications and administer medications separately." An observation of Registered Nurse (RN) #1 during medication pass on 3/13/2024 at 8:12 AM,	F 658	F658 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The facility failed to follow professional standards of practice for a feeding tube as evidenced by crushing and administering multiple medications at once without the use of gravity and failure to follow physician orders for water flushes for one (1) of five (5) residents observed during medication administration. Resident #43 1. Upon notification of the deficient practice, the Director of Nursing immediately assessed resident #43 with no adverse effects from deficient practice. The Director of Nurses completed a one-on-one education with Register Nurse #1 on March 14, 2024 regarding policy for administering medications through nasogastric or gastrostomy tube with emphasis on policy and procedure #7(check placement, flush before administering medications and administer each crushed medication separately with 5cc of water between each medications followed by flushed when finished) # points to remember #1 (use gravity when giving medications or flushing tube) and #8 (flush with 30cc of water per MD order before and after giving meds, flush with	

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F 658	Continued From page 15 revealed he prepared and crushed together the following medications to administer by percutaneous endoscopic gastrostomy (PEG) tube to Resident #43: 1. Fenofibrate (cholesterol reducer) 145 MG (milligrams) 1 (one) tablet 2. Pepcid (stomach acid reducer) 20 MG (milligrams) 1 (one) tablet 3. Sinemet (Parkinson's symptoms) 25-100 MG (milligrams) 1 (one) tablet 4. Sodium Bicarb (bicarbonate) (neutralizes stomach acid) 650 MG (milligrams) 1 (one) tablet RN #1 prepared Potassium Chloride (potassium supplement) 15 (milliliters) 20 MEQ (milliequivalents), entered Resident #43's room, mixed all the medications together with 30 ML (milliliters) of water in a syringe and administered the medications at once by pushing the plunger on the end of the syringe. On 3/13/2024 at 8:30 AM, in an interview with Registered Nurse (RN) #1, confirmed he did not administer Resident #43's PEG medications by gravity or crush and administer each medication separately. He revealed that the purpose of giving the medications separately and by gravity was to ensure the medications were compatible and that the tube did not clog and cause the resident complications. He stated the resident had a physician order to crush and administer the medication together. Record review of Resident #43's "Physician Orders" revealed an order dated 5/05/2021, "Flush PEG (percutaneous endoscopic gastrostomy) w/ (with) 30 CC (cubic centimeters) of H20 (water) before and after med (medication) administration and w/ (with) 5 (five) CC (cubic centimeters) of H20 (water) between each med	F 658	5cc between each medications) . 2. One of the fifty-six residents that are provided medications through nasogastric or gastrostomy tube have the potential to be affected by this deficient practice. 3. Director of Nursing also initiated an In-service with all nursing staff on March 18, 2024 the Director of Nursing also initiated an In-service with all nursing staff regarding the policy of administering medications through nasogastric or gastrostomy tube. Upon hire, annually and as needed, all nursing staff will receive orientation training by the Staff Development Nurse regarding care practices regarding policies and procedures for medication administration. All nursing staff upon hire completed a skills competency evaluation by the Staff Development Nurse regarding resident care practices including medication administration. 4. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and 2 x monthly to discuss findings from annual survey in reference to professional standards of practice on administering multiple medications through a nasogastric or gastrostomy tube. Beginning 3-19-2024, The Director of Nursing, Staff Development Nurse and	

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F 658	Continued From page 16 (medication) ..." On 3/13/2024 at 9:20 AM, in an interview with the Director of Nursing (DON) confirmed Resident #43 did not have a physician order to give PEG medications crushed together. She confirmed RN #1 did not follow the physician order for medication administration and revealed PEG medications should flow by gravity so that the tube does not mess up and cause problems for the resident. Record review of the "Face Sheet" revealed the facility admitted Resident #43 on 8/20/2020 with medical diagnoses that included Urinary Tract Infection, Gastrostomy Malfunction, unspecified Dementia, Parkinson's disease, Dysphagia, and unspecified severe protein-calorie malnutrition.	F 658	Pharmacy Consultant will monitor medication administrator regarding nasogastric or gastrostomy tube with emphasis on policy and procedure for administering medications at least 3 x weekly for 4 weeks then one time weekly for 4 weeks if no other problems identified. The Director of Nursing and Staff Development Nurse will report any recurring problems to the monthly Quality Assessment and Improvement Committee. The Administrator and Director of Nursing will take necessary corrective action such as: Individual in services, re-In-service, or disciplinary action up to and including termination of employees and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI committee will implement corrections or changes as needed.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to provide personal hygiene to residents as evidenced by unshaven facial hair for two (2) of 18 sampled residents. Resident #3 and Resident #40.	F 677	F677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS The facility failed to provide personal hygiene to residents as evidenced by unshaven facial hair for two (2) of 18	4/11/24

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F 677	Continued From page 17 Findings Include Record review of the facility policy titled, "A.M. Care" with a Latest Review date of 01/24, revealed "Purpose: To prepare the resident for their day ...To maintain the resident's desired physical appearance ... Procedure... 12. Assist the resident with grooming according to their preferences... shaving and hair removal..." Resident #3 An observation on 03/12/24 at 08:07 AM and again at 12:05 PM, revealed Resident #3 had facial hair approximately one-half (1/2) inch long to her chin area and beside her mouth. An interview and observation on 03/12/24 at 03:55 PM, Certified Nurse Aide (CNA) #1 revealed the aides are responsible for bathing their residents which also includes oral care and shaving them. She revealed it's usually done on the day shift. She confirmed that Resident #3 needed to be shaved and wasn't sure when it was done last. An interview and observation on 03/12/24 at 04:10 PM, the Director of Nurses (DON) revealed that the CNA's on any shift can shave and do activities of daily living (ADL) care for the residents, she confirmed Resident #3 needed to be shaved and she would make sure it gets done. A record review of Resident #3's "Face Sheet" revealed the resident was admitted to the facility on 10/18/19 with medical diagnoses that included Peripheral vascular disease and Vitamin	F 677	sampled residents. Resident #3 and Resident #40. 1. Director of Nursing was notified of this deficient practice on 3/12/2024. Immediately following notification, the Director of Nursing, instructed the Certified Nursing Assistant's to perform ADL care in reference to shaving for both residents. The Director of Nursing also assessed resident #3 and Resident #40 with no adverse effects from this deficient practice. The licensed nurses on each hall observed all residents to ensure compliance with AM care. 2. All fifty-six residents have the potential to be affected by this deficient practice. 3. An in-service was initiated on 3/13/24 for all nursing staff by the Staff Development Nurse regarding performance of AM care with all residents with emphasis on shaving of residents daily. The Director of Nursing, Staff Development and RN Supervisor will monitor ADL care for all residents with emphasis on providing personal hygiene and evaluating for facial hair beginning March 19, 2024 at least 3 x weekly for 4 weeks and then 1 time a week for 4 weeks if no other problems identified. 4. The Director of Nursing, Staff Development and RN Supervisor will monitor ADL care for all residents with emphasis on providing personal hygiene and evaluating for facial hair beginning March 19, 2024 at least 3 x weekly for 4	

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F 677	Continued From page 18 deficiency. Resident #40 An observation on 03/12/24 at 9:35 AM and again at 12:00 PM, revealed Resident #40 with a moderate amount of facial hair approximately 1 inch long to her chin and above her upper lip. During an interview on 03/12/24 at 03:25 PM, CNA #2 revealed the CNAs on the day shift rotation are responsible for shaving residents if they need it, she revealed it's usually done when they first wake up and do their baths or oral care. An interview and observation on 03/12/24 at 04:27 PM, the DON revealed any CNA can do ADL care regardless of the shift. She confirmed that Resident #40 had long facial hair and it needed to be taken care of. A record review of Resident #40's "Face Sheet" revealed the resident was admitted to the facility on 1/08/24 with medical diagnoses that included Acute kidney failure and Hypercalcemia.	F 677	weeks and then 1 time a week for 4 weeks if no other problems identified. Director of Nursing, Staff Development Nurse and RN Supervisor will report any recurring problems to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as: Individual in services, re-In-service, and or disciplinary action up to an including termination of employees and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI committee will I implement corrections or changes as needed. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and 2 x monthly to discuss findings from annual survey in reference to providing personal hygiene with emphasis on facial hair.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed	F 759	F759 FREE OF MEDICATION ERROR RTS 5 PRCNT OR MORE	4/11/24

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F 759	Continued From page 19 to ensure the medication error rate was not five (5) percent (%) or greater for (5) of (29) medication opportunities. The medication error rate was 17.24%. Resident #43 Findings Include: Review of the facility policy titled "Administering Medications Through Nasogastric or Gastrostomy Tube" with a revision date of 03/2018 revealed " ...Procedures: ... 7. After verifying proper placement of tube, flush it with a least 30 cc [cubic centimeters] of water before administering medications. Administer each medication separately, mix crushed medication with 5 cc [cubic centimeters] of water and flush the feeding tube with at least 5 cc of water between medications unless fluids are restricted ...Points To Remember: ... 8. Flush with 5 cc of water between medications and administer medications separately ...." An observation with Registered Nurse (RN) #1 during medication pass on 3/13/2024 at 8:12 AM, with Resident #43 revealed he prepared and crushed together the following medications: Fenofibrate (cholesterol reducer), Pepcid (stomach acid reducer), Sinemet (Parkinson's symptoms) and Sodium Bicarb (bicarbonate) (neutralizes stomach acid). RN #1 then administered the mixed medications to Resident #43 by percutaneous endoscopic gastrostomy (PEG) tube by pushing the end of the syringe. An interview with RN #1 on 3/13/2024 at 8:30 AM, confirmed he did not crush and administer Resident #43's PEG medication separately. He revealed the purpose of giving the medications separately was to ensure the medications were	F 759	The facility failed to ensure the medication error rate was not five (5) percent (%) or greater for (5) of (29) medication opportunities, The medication error rate was 17.24%. Resident #43 1. Upon notification of the deficient practice, the Director of Nursing immediately assessed resident #43 with no adverse effects from deficient practice. The Director of Nurses completed a one-on-one education with Register Nurse #1 on March 14, 2024 regarding policy for administering medications through nasogastric or gastrostomy tube with emphasis on policy and procedure #7 (check placement, flush before administering medications and administer each crushed medication separately with 5cc of water between each medications followed by flushed when finished) # points to remember #1 (use gravity when giving medications or flushing tube) and #8 (flush with 30cc of water per MD order before and after giving meds, flush with 5cc between each medications) . 2. One of the fifty-six residents that are provided medications through nasogastric or gastrostomy tube have the potential to be affected by this deficient practice. 3. Upon hire, annually and as needed, all nursing staff will receive orientation training by the Staff Development Nurse regarding care practices regarding policies and procedures for medication administration. All licensed nursing staff	

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F 759	Continued From page 20 compatible and to ensure the tube did not clog and cause complications for the resident. He stated the resident had a physician order to crush and administer the medications together. Record review of Resident #43's March 2024 "Physician Orders" revealed an order dated 5/05/2021, "Flush PEG w/ [with] 30 CC [cubic centimeters] of H20 [water] before and after med [medication] administration and with 5 [five] CC of H20 between each med ..." An interview on 3/13/2024 at 9:20 AM, with the Director of Nursing (DON) confirmed Resident #43 did not have a physician order to give PEG medications crushed together. She confirmed RN #1 did not follow the physician order for medication administration. Record review of the "Face Sheet" revealed the facility admitted Resident #43 on 8/20/2020 with medical diagnoses that included Parkinson's disease and Dysphagia.	F 759	received a skills competency evaluation by the Staff Development Nurse regarding resident care practices including medication administration. Director of Nursing also initiated an In-service on 3-18-2024 with all nursing staff regarding the policy of administering medications through nasogastric or gastrostomy tube. 4. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and monthly x 2 months to discuss findings from annual survey in reference to professional standards of practice on administering multiple medications through a nasogastric or gastrostomy tube. Beginning 3-19-2024, the Director of Nursing, Staff Development Nurse and Pharmacy Consultant will monitor medication administrator regarding nasogastric or gastrostomy tube with emphasis on policy and procedure for administering medications through nasogastric or gastrostomy tube at least 3 x weekly for 4 weeks then one time weekly for 4 weeks if no other problems identified. The Director of Nursing and Staff Development Nurse will report any recurring problems to the monthly Quality Assessment and Improvement Committee. The Administrator and Director of Nursing will take necessary	

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F 759	Continued From page 21	F 759	corrective action such as: Individual in services, re-In-service, or disciplinary action up to and including termination of employees and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI committee will implement corrections or changes as needed.	
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to ensure linen barrels did not block fire doors on one of two halls for one (1) of four (4) days of survey. This had the potential to affect 56 residents residing in the facility. Findings Include Record review of the facility policy titled, "Safety and Security Plan" with a revision date of 4/23 revealed "#19 ...Arrange equipment such as wheelchairs, tables, linen carts, etc., so as not to block aisles, exits, fire fighting equipment, alarm boxes, electric lighting, or power panels, etc...FIRE DOORS MUST BE KEPT CLEAR AT ALL TIMES ..." An observation on 03/11/24 at 6:45 PM, revealed the double fire doors leading to Hall 200 were open with two linen barrels propped against one	F 921	F921 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility failed to ensure linen barrels did not block fire doors on one of two halls for one (1) of four (4) days of survey. This had the potential to affect 56 residents residing in the facility. 1.Immediately upon notification of this deficient practice, the linen barrels were removed by the hallway nurse on 3-11-2024 from blocking the fire doors. Licensed Practical Nurse LPN #2 observed the hallway and resident rooms on 3-11-2024 with no adverse effects from barrels being in front of fire doors. Administrator initiated an In-service on 3/12/24 regarding the safety policy for ensuring all fire doors are clear from	4/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255284	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	3103 WISCONSIN AVENUE VICKSBURG, MS 39180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 22 of the doors. An observation and interview on 3/11/24 at 7:00 PM, with Licensed Practical Nurse (LPN) #2 confirmed the linen barrels were propped against the fire doors leading to Hall 200. She stated that they did not need to be propped on the hall double doors due to it could be a fire hazard preventing the doors from closing completely if the fire alarm went off. An interview on 3/12/24 at 11:00 AM, with the Administrator confirmed that linen barrels or anything else do not need to be stored in the double/fire doors to the hall because if the fire alarm goes off then it could prevent them from closing causing a fire hazard. She stated we have to stay on them about that. She stated that the facility staff is educated on hire, annually and as needed to keep equipment etc. from being in front of fire doors so in case the system is activated the fire doors will be able to automatically shut as designed. The education for keeping items away from fire doors is a part of the safety, fire disaster portion of the orientation checklist and re-education when conducting fire drills as needed.	F 921	equipment such as lifts, linen barrels, trash barrels, carts etc. to ensure doors will close in the event of an emergency. 2 All fifty-six residents that reside in the facility have the potential to be affected from this deficient practice. 3. Administrator initiated an In-service on 3/12/24 with all staff regarding the safety policy for ensuring all fire doors are clear from equipment such as lifts, linen barrels, trash barrels, carts etc. to ensure doors will close in the event of an emergency. Upon hire, annually and as needed the staff are trained on the safety plan of the facility to include keeping the fire doors clear at all times so they will automatically close in case of an emergent event. 4. The Administrator, Director of Nursing, RN Supervisor and Charge nurse will monitor hallways beginning March 13, 2024 at least 3 x weekly x 4 weeks then 1 x weekly for 4 weeks for compliance of fire doors being kept clear at all times. An initial Quality Assurance Committee Meeting was conducted on March 22, 2024 and a follow up Quality Assurance Committee Meeting will be conducted on April 3, 2024 and 2 x monthly to discuss findings from annual survey in reference to safety regarding fire doors kept clear at all times.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255284	A. BUILDING _____ B. WING _____	03/14/2024

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F 921	Continued From page 23	F 921	Administrator and Director of nursing will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as: Individual in services, re-Inservice or disciplinary action up to an including termination of employees and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI committee will implement corrections or changes as needed.	