STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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 Complaint Investigation (CI) MS #16667 from 08/31/2020 through 09/01/2020. The SA determined the facility not to be in compliance with the requirements of participation in Medicare and Medicaid. The facility was cited the regulatory deficiencies at F656 and F657. At the time of the survey, the facility had a census of 84, and held a license for 120 beds.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		10/20/20

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

Electronically Signed | 10/12/2020

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (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. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and facility policy review, the facility failed to implement interventions to help prevent infections on catheter care plans for two (2) of four (4) residents records reviewed, Resident #3, and Resident #4. Findings include: Review of the facility's "Comprehensive Care Plan Policy", dated 03/2019, revealed, Standard: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measure objective and timeframe's to meet a resident's medical, nursing, and mental ad psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or	F 656	* Care plans of the resident identifiers (RI) #s 3 and 4 were reviewed and updated as indicated by the Director of Nursing (DON). Resident # 3 and #4 were assessed for signs or symptoms of infection by the DON and resident #3 and #4 did not have any signs or symptoms of infection identified. * The facility has determined that all residents with Foley or Suprapubic catheters have the potential to be affected. Four residents with Foley or Suprapubic catheters were identified who could be considered at risk, charts were reviewed, orders and care plan in place. * All interdisciplinary care plan team members responsible for writing care plans were re-educated on the facility□s policy and procedure for developing	

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F 656	Continued From page 2 maintain the resident's highest practicable physical, mental, and psychosocial well-being. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Resident #3 Review of Resident #3's Care Plan, revealed, Focus: Risk for complications related to (r/t) Foley cath r/t Neurogenic Bladder. Desired Outcomes: Measures will be implemented to decrease risk for infection and complication r/t cath thru next review. Interventions/Tasks: Daily cath care with soap and water every shift and as needed. Review of Resident #3's current Physicians Orders, revealed, an order for "Foley Cath Care with soap and water every shift and as needed." Review of Resident #3's Annual Minimum Data Set (MDS), dated 07/22/2020, revealed, she was not interviewable and was unable to complete a cognitive assessment due to dementia. She required total assistance of one person for her incontinence and catheter care. During an interview with Licensed Practical Nurse (LPN) #1, on 09/01/2020 at 10:20 AM, she stated, the cart nurses were responsible to clean the suprapubic catheters once a day and place a gauze on them, and the Certified Nurse Aides (CNAs) were supposed to do the regular catheter care every shift and report it to the nurse to chart in the computer when it is done. During an interview with LPN #2, on 09/01/2020 at 10:40 AM, she stated the CNAs were	F 656	Comprehensive Care Plans. All nursing staff was provided an in-service by the Wound Care Nurse Manager on documentation requirements in the Treatment Administration Record (TAR). * Care plans will be reviewed weekly in accordance with the care plan review schedule by the Minimum Data System (MDS) Coordinators. All care plans will be updated as indicated. * The Director of Nursing (DON) will complete random weekly audits of five care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. * The Wound Care Nurse Manager will audit treatment administration records (TARS) weekly for compliance with daily documentation on the TAR. The Wound Care Nurse Manager will provide education as needed with direct care staff to ensure documentation is completed every shift. * Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee consists of the Medical Director, DON, Assistant Director of Nursing, Nurse Educator, MDS, Central Supply, and Social Services.	

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F 656	Continued From page 3	F 656		

responsible for doing the catheter care at least one time a shift, when they are giving incontinence care. LPN #2 stated the nurse makes sure it was done, and then charts it on the computer.

During an interview, with LPN #3, on 09/01/2020 at 3:15 PM, she stated the nurses are responsible to ensure the CNAs are doing catheter care at least one time a shift, and the nurses chart it on the computer every shift that it is done. She stated a lot of times they forget because they have to go to another screen in the computer to get to the treatment sheets.

Review of Resident #3's Treatment Administration Record (TAR), dated for June 2020, revealed, an order for "Foley Cath Care with soap and water every shift and as needed." Signatures of completion were missing for all three shifts on 06/24/2020. Signatures of completion were missing for two (2) of three (3) shifts on 06/01/2020, 06/03/2020, 06/04/2020, 06/05/2020, 06/08/2020, 06/09/2020, 06/10/2020, 06/11/2020, 06/14/2020, 06/16/2020, 06/17/2020, 06/26/2020, 06/28/2020, and 06/302020. Signatures of completion were missing for one (1) out of 3 shifts on 06/02/2020, 06/06/2020, 06/07/2020, 06/12/2020, 06/13/2020, 06/15/2020, 06/18/2020, 06/19/2020, 06/20/2020, 06/22/2020, 06/23/2020, 06/25/2020, 06/27/2020, and 06/29/2020. There was only one day in the month of June that signatures of completion were present on all 3 shifts, which was on 06/21/2020.

Review of Resident #3's TAR, dated for July 2020, revealed, an order for "Foley Cath Care with soap and water every shift and as needed." Signatures of completion were missing for all

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F 656	Continued From page 4	F 656		

three shifts on 07/19/2020. Signatures of completion were missing on 2 of 3 shifts on 07/01/2020, 07/05/2020, 07/08/2020, 07/09/2020, 07/10/2020, 07/14/2020, 07/16/2020, 07/18/2020, 07/20/2020, 07/22/2020, 07/23/2020, and 07/28/2020. Signatures of completion were missing for 1 of 3 shifts on 07/02/2020, 07/03/2020, 07/04/2020, 07/06/2020, 07/12/2020, 07/13/2020, 07/15/2020, 07/17/2020, 07/21/2020, 07/24/2020, 07/25/2020, 07/27/2020, 07/29/2020, 07/30/2020, and 07/31/2020. There were only 3 days in the month of July 2020 that signatures of completion were present on all 3 shifts, which were 07/07/2020, 07/11/2020, and 07/28/2020.

Review of Resident #3's TAR, dated for August 2020, revealed, an order for "Foley Cath Care with soap and water every shift and as needed." Signatures of completion were missing for all three shifts on 08/16/2020 and 08/30/2020. Signatures of completion were missing for 2 of 3 shifts on 08/06/2020, 08/07/2020, 08/12/2020, 08/14/2020, 08/15/2020, 08/17/2020, 08/24/2020, and 08/28/2020. Signatures of completion were missing for 1 of 3 shifts on 08/01/2020 through 08/05/2020, and 08-08-2020.

During an interview, with the Director of Nursing (DON),on 09/02/2020 at 11:00 AM, upon review of Resident #3's catheter care plan, and TARs, she confirmed the multiple, missing signatures of completion. She stated, without signatures on the treatment sheets, there is no way to prove the catheter care was done. The DON stated, if it is not documented, it is not done. She revealed they had several new nurses and they have to go to a separate section on the computer to chart the treatments, and it looked like they have missed a lot of shifts.

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Review of Resident #3's medical record, revealed, she was admitted by the facility on 10/30/2008, with diagnoses that included Hemiplegia of the Left side, Dementia, Diabetes, Stage IV Sacral Pressure Ulcer, Hyperlipidemia, Epilepsy, Neuromuscular Dysfunction of the Bladder, and Hypertension.

Resident #4
Review of Resident #4's Care Plan revealed, "Focus: (Formal Name) has a suprapubic catheter secondary to a DX of Neurogenic Bladder. Desired Outcome: (Formal Name) will have no undetected signs/symptoms of infection using staff interventions through next review date. Interventions/Tasks: Catheter care every shift with soap and water as ordered.

Review of Resident #4's current Physician's Orders, revealed, an order to "Cleanse suprapubic catheter with soap and water everyday" and an order for a "Suprapubic Catheter care pack with Hydrofera Blue cover with 4X4 and ABD pad secure with tape every other day."

Review of Resident #4's Medicare five (5) day MDS, dated 07/20/2020, revealed, he scored 5 on the Brief Interview for Mental Status (BIMS), which indicated severely impaired cognitive status. He required total assistance of one person for incontinence and catheter care.

During an interview with Resident #4, on 09/01/2020 at 2:45 PM, regarding his catheter care, he stated, they (staff) don't change the sponge like they are supposed to. He revealed

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there was no sponge around his catheter at the time of the interview. Resident #4 removed his blanket and it was observed that he did not have any type of dressing around his Suprapubic catheter.

Review of Resident #4's TAR, dated for June 2020, revealed an order to "Cleanse Suprapubic catheter with soap and water every day". Signatures of completion were missing on 06/03/2020, 06/13/2020, 06/14/2020, 06/27/2020, 06/28/2020 and 06/30/2020. Resident #4's TAR also revealed, an order for a "Suprapubic catheter care pack with Hydrofera Blue cover with a 4x4 and ABD pad, secure with tape every other day." Signatures of completion were missing for 06/03/2020, 06/13/2020, 06/27/2020 and 06/30/2020.

Review of Resident #4's TAR, dated for July 2020, revealed, an order to "Cleanse Suprapubic catheter with soap and water every day." Signatures of completion were missing on 07/04/2020, 07/08/2020, 07/19/2020, 07/25/2020, and 07/26/2020. Resident #4's TAR further revealed an order for a "Suprapubic catheter care pack with Hydrofera Blue cover with a 4x4 and ABD pad, secure with tape every other day." Signatures of completion were missing for 07/19/2020 and 07/25/2020.

A review of Resident #4's TAR, dated for August 2020, revealed an order to "Cleanse Suprapubic catheter with soap and water every day." Signatures of completion were missing on 08/01/2020, 08/02/2020, 08/06/2020, 08/082020, 08/09/2020, 08/19/2020, 08/22/2020, 08/23/2020, 08/24/2020, and 08/30/2020. Resident #4's TAR also revealed an order for a "Suprapubic catheter

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F 656	Continued From page 7 care pack with Hydrofera Blue cover with a 4x4 and ABD pad, secure with tape every other day." Signatures of completion were missing for 08/02/2020, 08/06/2020, 08/08/2020, 08/22/2020, 08/24/2020, 08/30/2020, and 08/31/2020. During an interview, with the DON, on 09/02/2020 at 11:00 AM, to review Resident #4's catheter care plans and TARs, with the multiple missing signatures of completion, she stated, without documentation, they couldn't prove the catheter care was done. Review of Resident #4's medical record, revealed, he was admitted by the facility on 05/02/2016, with diagnoses which included, Dementia, Depression, Neuromuscular Dysfunction of the Bladder, History of Urinary Tract infection and Hemiplegia/Hemiparesis of the Left Side.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		10/20/20

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F 657	Continued From page 8 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to update and revise resident care plans with current physician's orders for Foley catheter care, for two (2) of four (4) residents records reviewed. Residents #1 and #2. Findings include: Review of the facility's "Comprehensive Care Plan Policy", dated 03/2019, revealed: Standard: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measure objective and timeframe's to meet a resident's medical, nursing, and mental ad psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after	F 657	* On 9/2/2020 the Minimum Data System (MDS) Coordinator updated the care plan for Resident # 1 and Resident # 2 to reflect Foley Catheter care every shift to be provided per the physician orders. * Any residents of the facility with Foley or Suprapubic Catheters have the potential to be affected by this practice. On 9/2/2020 the Director of Nursing (DON) reviewed all current residents (four total residents) with Foley Catheter and Suprapubic Catheter needs and ensured the care plan was updated. * On 9/3/2020 the MDS coordinator is running an order recap report for the previous 24 hour period and each order is discussed with the interdisciplinary team and care planning completed as needed including catheter related orders. * All interdisciplinary care plan team members responsible for coordinating and implementing the comprehensive care	

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each comprehensive and quarterly Minimum Data Set (MDS) assessment. Alternative interventions will be documented, as needed.

Resident #1
Review of Resident #1's Care Plan, revealed, Focus: Resident #1 has Suprapubic Catheter secondary to Neuromuscular Dysfunction Bladder. Desired Outcome: Resident #1 will be/remain free from catheter-related trauma through review date. Further review of the interventions on the care plan, revealed, there was no mention of performing Foley catheter care every shift per the physicians orders. Resident #1's care plan also revealed a Focus area, dated 08/25/2020, regarding Resident #1 receiving antibiotics for Urinary Tract Infection (UTI). Desired outcome: Resident #1 will show no signs/symptoms of urinary infection through review date. Further review of the interventions, revealed no mention of Foley catheter care every shift per the Physician's Orders.

Review of Resident #1's current Physician's Orders, revealed, an order for "Cath care with soapy water every shift", and an order to "Clean Suprapubic cath site with NS (Normal Saline); pat dry; apply split sponge gauze everyday and prn (as needed)."

Review of Resident #1's Quarterly Minimum Data Set (MDS) dated 07/21/2020, revealed, she was not interviewable and was unable to participate in cognitive testing due to Dementia. She required total assistance of one person for her incontinence and catheter care needs.

During an interview, with the Director of Nursing (DON), on 09/02/2020 at 2:30 PM, the State

plan have been re-educated on the facility□s policy and procedure: Care Planning □ Timing and Revision by the Nurse Educator.

* The Director of Nursing (DON), will conduct a weekly random audit of five (5) residents□ for a period of four (4) consecutive weeks to ensure that the residents comprehension care plan is complete, accurate, and updated with current physician orders.

* Audit records will be reviewed by the Risk Management/Quality Assurance Committee Monthly until such time consistent substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee consists of the Medical Director, DON, Assistant Director of Nursing, Nurse Educator, MDS, Central Supply, and Social Services.

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Agency (SA) surveyor asked to speak to the care plan nurse to address care plan revisions. The DON stated she would answer any care plan questions, because they had recently fired the last Care Plan Nurse. She stated the nurse taking her place was new and still in training. After reviewing the care plans for Resident #1, the DON stated, the interventions were not on either care plan.

Review of Resident #1's medical record revealed, she was admitted by the facility on 03/15/2018, and had diagnoses which included Alzheimer's, Disorder of the Bladder, Cystostomy, Stage IV Sacral Pressure Ulcer, History of UTI, Paraplegia, and Neuromuscular Dysfunction of the Bladder.

Resident #2
Review of Resident #2's Care Plan revealed, a Focus: Resident #2 has an Indwelling Catheter; 18 French (fr) 20 cubic centimeters (cc) foley catheter to gravity. Desired Outcome: Resident #2 will show no signs/symptoms of Urinary infection through review date. Resident #2 will be/remain free from catheter-related trauma through review date. Further review of Resident #2's care plan, revealed, there was no mention of Foley catheter care every shift per the Physician's Orders.

Review of Resident #2's current Physician's orders, revealed, an order for "Foley cath care with soap and water every shift and as needed."

Review of Resident #2's Annual MDS, dated 07/20/2020, revealed, she was not interviewable and was unable to participate in the cognitive assessment due to cognitive decline. She

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PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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
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required total assistance of one person for her incontinence and catheter needs.

During an interview, with the Director of Nursing (DON), on 09/02/2020 at 2:30 PM, she stated she would answer any care plan questions, because they had recently fired the last Care Plan Nurse. After reviewing the care plan for Resident #2, the DON stated the interventions for Foley catheter care was not on Resident #2's care plan.

Review of Resident #2's medical record revealed, she was admitted by the facility on 08/06/2019, with diagnoses which included, Aphasia, Stage IV Sacral Pressure Ulcer, Epilepsy, Diabetes, and Bilateral Above Knee Amptuation (AKA).